Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

IDENTIFICATION

Practitioner _____

Name _____ Sex ❑ M ❑ F Date _____

Address _____ City _____ State _____ Zip _____

Telephone: Home _____ Work _____ Cell _____

Date of Birth _____ Age _____ Email _____

❑ Single ❑ Married ❑ Partnered ❑ Widowed ❑ Separated/Divorced

Height _____ Weight _____ Occupation _____

Education _____

Emergency contact _____ Relation _____

Emergency contact telephone: Home _____ Cell _____

Name of physician* _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Name of counselor/psychologist* _____ Phone number _____

Address _____ City _____ State _____ Zip _____

Name of gynocologist* _____ Phone number _____

Address _____ City _____ State _____ Zip _____

* No contact will be made without your permission.

Your signature _____

Special problems or symptoms _____

_____

_____

_____

– over –

FAMILY HISTORY Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)	N/A					

PERSONAL LIFESTYLE HABITS For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day) _____
Alcohol (drinks per week) _____
Drug use (recreational) _____

Coffee/Tea (cups per day) _____
Soda (regular or diet) _____
Exercise ❑ Yes ❑ No How often? _____
What kind of excercise? _____

MEDICAL If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS	HOSPITAL OR TREATMENT LOCATION

MEDICINES Please list all medications, vitamins and/or food supplements you are currently taking:

Medications _____ Dosage _____ For what condition? _____
_____ _____ _____
_____ _____ _____
_____ _____ _____

Vitamins _____ Dosage _____ For what condition? _____
_____ _____ _____
_____ _____ _____

Food Supplements _____ For what condition? _____
_____ _____
_____ _____
_____ _____

CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

General

____ Insomnia
____ Dreams/ nightmares
____ Fatigue
____ Poor memory
____ Strongly like cold drinks
____ Strongly like hot drinks
____ Recent weight loss/gain
____ Cold hands & feet
____ Chills
____ Fever
____ Bad breath
____ Other (describe)

_____

Head & Neck

____ Headaches
____ Migraines
____ Stiff neck
____ Dizziness
____ Fainting
____ Swollen glands
____ Other (describe)

_____

Ears

____ Ringing
____ Hearing loss
____ Hearing aids
____ Infections
____ Earache
____ Vertigo
____ Other (describe)

_____

Eyes

____ Glasses/ contact lenses
____ Blurred vision
____ Poor night vision
____ Spots or floaters
____ Eye inflammation
____ Double vision
____ Glaucoma
____ Cataracts
____ "Lazy" eye
____ Other (describe)

_____

____ How often checked?

_____

Nose, Throat & Mouth

____ Sinus infection
____ Hay fever/ allergies
____ Frequent sore throat
____ Difficulty swallowing
____ Mouth & tongue ulcers
____ Frequent colds
____ Nosebleed
____ Dry nose
____ Nasal congestion
____ Loss of voice
____ Thirst
____ Excessive phlegm
____ TMJ
____ Facial pain
____ Gum problems
____ Dry mouth
____ Other (describe)

_____

____ Dental problems? Last visit

_____

Skin

____ Hives
____ Rashes
____ Eczema/ psoriasis
____ Night sweating
____ Excess sweating
____ Dry skin
____ Easily bruised
____ Changes in moles, lumps
____ Itching
____ Other (describe)

_____

Respiratory

____ Difficulty breathing
____ Difficulty breathing when reclining
____ Wheezing
____ Asthma
____ Chronic cough
____ Wet cough
____ Dry cough
____ Coughing up phlegm
____ Coughing up blood
____ Shortness of breath
____ Tight chest
____ Pneumonia
____ Other (describe)

_____

Cardiovascular

____ High blood pressure
____ Low blood pressure
____ Chest pain or tightness
____ Palpitation
____ Rapid heart beat
____ Irregular heart beat
____ Poor circulation
____ Swollen ankles
____ Phlebitis
____ Anemia
____ History of heart disease
____ Heart murmur
____ Night sweats
____ Tendency to be cold
____ Tendency to be warm
____ Other (describe)

_____

Gastrointestinal

____ Nausea
____ Indigestion
____ Stomach pain
____ Diarrhea
____ Constipation
____ Poor appetite
____ Excessive hunger
____ Vomiting
____ Gas
____ Hiccups
____ Acid regurgitation
____ Bloating
____ Laxative use
____ Bloody stool
____ Other (describe)

_____

Musculoskeletal

____ Joint pain/swelling
____ Sore muscles
____ Weak muscles
____ Difficulty walking
____ Pain (describe)

_____
_____
_____

____ Limited range of motion
____ Other (describe)

_____

– over –

Neurological

____ Seizures
____ Tremors
____ Numbness or tingling
____ Pain (describe)
____ Paralysis
____ Poor coordination
____ Other (describe)

____

Mental/Emotional

____ Depression
____ Mood swings
____ Irritability
____ Difficulty relaxing
____ Loneliness
____ Sensitive
____ Shyness
____ Frequent crying
____ Worries frequently
____ Compulsive behaviors
____ Difficulty focusing
____ Hopeless outlook
____ Suicidal thoughts
____ Lose temper
____ Frustration
____ Other (describe)

____

Urinary

____ Pain on urination
____ Frequent urination
____ Urgent urination
____ Blood in urine
____ Incontinence
____ Incomplete urination
____ Bedwetting
____ Wake to urinate
____ History of URI
____ Kidney (specify)

____
____

____ Other (describe)

____

Male Genital

____ Impotence
____ Premature ejaculation
____ Nocturnal emission
____ Pain/itching of genitalia
____ Lumps in testicles
____ Increased libido
____ Decreased libido
____ Breast checked
____ Other (describe)

____

Gynecology (Women Only)

____ Currently pregnant
____ # of Pregnancies
____ # of Live births
____ # of Miscarriages
____ # of Abortions
____ Menopause
____ Irregular periods
____ Menstrual cramps
____ Excessive blood flow
____ Menstrual blood clots
____ Breast tenderness
____ Abnormal pap smear
____ Vaginal infections
____ Vaginal pain/itching
____ Uterine fibroids
____ Endometriosis
____ Breast lumps, cysts
____ Increased libido
____ Decreased libido
____ Other (describe)

____

Infection Screening (circle self and/or partner)

____ HIV risks: self or partner
____ TB: self or household
____ Hepatitis risk: self or partner
____ History of sexually transmitted disease: self or partner (specify)

____
____

____ Other (describe)

____

Trauma (list)

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Other Information

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____
Patient Signature

____
Date