PATIENT INTAKE FORM

Name: Phone: Home: Work/Mobile:

Street: Age: Ht: Wt:

City: Birth date: Sex:

State: ZIP: Occupation: Marital Status:

Primary Physician: Referred by:

Emergency Contact/Relation: Emergency #:

E-Mail address:

MAIN PROBLEM

PAST MEDICAL HISTORY (Including date):

Significant Illness: Cancer ___ Diabetes ___ High Blood Pressure ___ Heart Disease ___ Hepatitis ___
Rheumatic Fever ___ Thyroid Disease ___ Seizures ___ HIV ___ Other _____

Surgeries: _____

Significant Trauma: (auto accident, falls, etc.) _____

Birth History: (prolonged labor, forceps delivery, etc.) _____

Allergies: (drugs, chemicals, foods) _____

Medicines: (in the last 2 months i.e. OTC drugs, vitamins, herbs, etc.) _____

_____

Occupational Stresses: (chemical, physical, psychological, etc.) _____

Family Medical History: Cancer ____ Diabetes ____ High Blood Pressure ____ Heart Disease ____ HIV ____

Hepatitis ____ Stroke ____ Seizures ____ Asthma ____ Allergies ____ Alcoholism ____ Other _____

Daily diet: Morning: _____ Afternoon: _____ Evening: _____

Habits: Cigarettes ___ Coffee ___ Tea ___ Cola ___ Alcohol ___ Drugs ___ Sugar ___ Salt ___ Other _____

MEDICAL HISTORY: Please Check All That Apply

GENERAL:

☐ Poor appetite	☐ Heavy appetite	☐ Poor sleep	☐ Heavy Sleep
☐ Insomnia	☐ Fatigue	☐ Tremors	☐ Vertigo
☐ Cold hands	☐ Cold feet	☐ Cold back	☐ Cold abdomen
☐ Fevers	☐ Cravings	☐ Night sweats	☐ Sweat easily
☐ Chills	☐ Localized weakness	☐ Poor coordination	☐ Change in appetite
☐ Sudden energy drop	☐ Peculiar tastes/smells	☐ Strong Thirst	☐ Bleed or bruise easily

Other: _____

SKIN & HAIR

☐ Rashes	☐ Ulcerations	☐ Hives	☐ Itching
☐ Eczema	☐ Pimples	☐ Dandruff	☐ Loss of hair
☐ Change in hair, skin texture		☐ Purpura	☐ Boils

☐ Tumors, Masses or Lumps (where) _____

Other:

HEAD & NECK

- ☐ Dizziness
- ☐ Eye strain
- ☐ Color blindness
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Tooth problems
- ☐ Sores on lips or tongue
- ☐ Concussions
- ☐ Eye pain
- ☐ Cataracs
- ☐ Poor hearing
- ☐ Dry throat
- ☐ Jaw clicks
- ☐ Headaches/Migraines (where/when) _____
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Nose bleed
- ☐ Dry mouth
- ☐ Grinding teeth
- ☐ Recurrent sore throats _____/months
- ☐ Glasses/Contacts
- ☐ Night blindness
- ☐ Sinus problems
- ☐ Copious saliva
- ☐ Facial pain

Other _____

CARDIOVASCULAR

- ☐ High blood pressure
- ☐ Dizziness
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Swelling in hands/feet
- ☐ Difficulty breathing
- ☐ Chest pains
- ☐ Cold hands/feet
- ☐ Heart Medication
- ☐ Irregular heart beat
- ☐ Phlebitis

Other _____

RESPIRATION

- ☐ Asthma
- ☐ Cough
- ☐ Bronchitis
- ☐ Coughing blood
- ☐ C.O.P.D.
- ☐ Tight chest (how often) _____
- ☐ Pneumonia
- ☐ Production of phlegm (Amt/Freq): _____ Color: _____ Consistency: _____

Other _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Gas
- ☐ Bad breath
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Vomiting
- ☐ Belching
- ☐ Rectal pain
- ☐ Bloody stools
- ☐ Laxative use. Frequency of use: _____
- ☐ Diarrhea
- ☐ Black stool
- ☐ Hemorrhoids
- ☐ Sensitive abdomen
- ☐ Bowel Movement
  - _____ Frequency
  - _____ Color
  - _____ Odor
- ☐ Other _____

MUSCULOSKELETAL

- ☐ Neck pain (where): _____
- ☐ Back pain (where): _____
- ☐ Muscle pain (where): _____
- ☐ Joint pains (where): _____
- ☐ Other _____

NEUROPSYCHOLOGICAL

- ☐ Seizures
- ☐ Depression
- ☐ Treated emotional problems: _____
- ☐ Areas of numbness
- ☐ Anxiety
- ☐ Poor memory
- ☐ Bad temper
- ☐ Considered/attempted suicide
- ☐ Concussion
- ☐ Easily stressed
- ☐ Other _____

PREGNANCY & GYNECOLOGY

- ☐ Vaginal discharge
- ☐ Pregnancy (#) _____
- ☐ First menses (age) _____
- ☐ Last menses _____
- ☐ Vaginal Sores
- ☐ Miscarriage (#) _____
- ☐ Period (duration) _____
- ☐ Menopause (year) _____
- ☐ Breast Lumps
- ☐ Premature (#) _____
- ☐ Clots
- ☐ Last PAP(date)_____ Normal/Abnormal
- ☐ Births (#) _____
- ☐ Irregular periods
- ☐ Changes in body/psyche prior to menstruation _____
- ☐ Flow (describe)_____
- ☐ Birth control type & duration_____
- ☐ Other_____