New Patient Intake Form

Please take the time to thoroughly answer all questions. This form allows your doctor to provide appropriate care.

Date: _____

Patient Name: _____ DOB: _____

Occupation: _____Circle: Single Married Divorced

Number of Children: _____Ages of Children _____ _____ _____ _____ _____ _____

List your health concerns in order of importance:

1) _____
2) _____
3) _____
4) _____
5) _____

How does your greatest health concern limit you the most: _____

_____

How committed are you towards making valuable changes: Little Moderately Very

Name and telephone number of Primary Care physician: _____

_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:	_____	_____	_____	_____	_____	_____
Age when died:	_____	_____	_____	_____	_____	_____
Reason for death:	_____	_____	_____	_____	_____	_____
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

Patient Name: _____ DOB: _____

Please Note When & Why You Have Had Each of the Following:

X-Rays: _____ MRI/Cat Scans: _____ Ultrasounds: _____
Accidents: _____ TB Test: _____ HCV: _____
HIV: _____ Last Dental Visit: _____ Last Eye Exam: _____

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles : D I N Chicken Pox : D I N Hemophilus (Hib) : D I N
Rubella : D I N Tetanus : D I N Whooping Cough : D I N
Mumps : D I N Hepatitis B : D I N
Any vaccination reactions: _____

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids : Y N P Steroids : Y N P Smoking : Y N P Packs per day & number of years :___
Analgesics : Y N P Laxatives : Y N P Coffee : Y N P Cups per day if Yes/Past : _____
Soda Pop : Y N P Ounces per day if Yes/Past : _____
Alcohol : Y N P How often & how much if Yes/Past : _____
Any Alcohol Addiction : Y N P Any Alcohol Treatment : Y N P
Recreational Drugs : Y N P Any Drug Addictions : Y N P
Any Drug Treatment : Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and including dosage:

_____

_____

Review of Systems:

Present Weight : _____ Weight one year ago : _____ Height : _____
Maximum weight and when : _____ Minimum weight as adult & when : _____
Ideal Weight : _____

REGARDING THE NEXT LONG SECTION : Please circle (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST .

Good Energy : Y N P
Fatigue : Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst ? _____
If you have fatigue, can you do what you need to during the day ? Y N

Patient Name: _____ DOB: _____

SKIN

Rash:	Y N P		Color Change:	Y N P
Hives:	Y N P		Lump:	Y N P
Psoriasis/eczema:	Y N P		Itchy:	Y N P
Dry:	Y N P		Warts/moles:	Y N P
Cancer:	Y N P		Perspiration:	Y N P

HEAD

Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oil/dry hair:	Y N P		Hair loss:	Y N P

NOSE

Frequent Colds:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Post Nasal Drip:	Y N P
Polyps:	Y N P		Seasonal Allergies:	Y N P

EYES

Dry/Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Cataracts:	Y N P
Glaucoma:	Y N P		Styes:	Y N P
Strain:	Y N P		Discharge:	Y N P
Itchy:	Y N P		Dark under Eyelid:	Y N P

MOUTH/THROAT

Canker sores:	Y N P		Cold sores:	Y N P
Sore Throat:	Y N P		Gum disease:	Y N P
Dentures:	Y N P		Cavities:	Y N P
Dental Implants	Y N P		Root Canals	Y N P
Loss of taste:	Y N P		Hoarseness:	Y N P

NECK

Stiffness:	Y N P		Swollen Glands:	Y N P
Full movement:	Y N P		Tension:	Y N P

Patient Name: _____ DOB: _____

RESPIRATORY

Cough:	Y N P		TB:	Y N P
Shortness of breath w/ exertion:	Y N P		Bronchitis:	Y N P
Shortness of breath sitting:	Y N P		Pneumonia:	Y N P
Shortness of breath lying down:	Y N P		Asthma:	Y N P
Wheezing:	Y N P		Painful breathing:	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P		Rheumatic Fever:	Y N P
Low Blood Pressure	Y N P		Murmurs:	Y N P
Arrhythmias:	Y N P		Palpitations:	Y N P
Edema:	Y N P		Chest Pain:	Y N P

URINARY TRACT

Incontinence:	Y N P		Pain w/ Urination	Y N P
Frequent Infections:	Y N P		Kidney Stones	Y N P
Urgency:	Y N P		Discharge/Blood:	Y N P

GASTROINTESTINAL

Heartburn:	Y N P		Bowel Movement Freq:	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer	Y N P

MALE

Testicular pain/swelling:	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.:	Y N P
Discharge: Impotency:	Y N P Y N P		Prostate Disease/Symptoms:	Y N P

Patient Name: _____ DOB: _____

FEMALE

Age Period Began:			How Often Period Occurs:	
How long period lasts:			Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P		Menstrual Pain:	Y N P
PMS:	Y N P		Food cravings:	Y N P
Times Pregnant:			How many births:	
Miscarriages:			Abortions:	
Last Pap Smear:				
Any abnormal paps:	Y N P		When was abnormal:	
Menopausal since what age:			Use of hormones:	Y N P
Type of hormones used:			Healthy libido:	Y N P
Dry vagina:	Y N P		Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P		Vaginitis:	Y N P
S.T.D.:	Y N P		Mammography:	Y N P
Bone Density Test:	Y N P		If Yes, what were results:	
Birth Control History: Type(s) and ages when used			Thermography: If yes, what were results:	Y N P

MUSCULOSKELETAL

Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P

NERVOUS

Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

Mental/Emotional

Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High-strung/tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating disorder:	Y N P		Psych Hospitalization:	Y N P

Patient Name: _____ DOB: _____

Exercise
How often do you exercise? _____ What type of exercise? _____
For how long? _____

Hobbies : _____

Sleep
How long per night? _____ If you wake up frequently, what is the reason? _____
Nightmares: Y N P Wake Refreshed: Y N P Must nap during the day: Y N P
Sleep walk: Y N P Grind teeth: Y N P Snore: Y N P

Toxin Exposure
Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? _____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? _____
_____
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? _____
Are you particularly sensitive to perfumes, gasoline or other vapors? _____
Do you use pesticides, herbicides or other chemicals around your home? _____

Social Life
Enjoy job: Y N P Hours worked per week: _____ Highest Level of Education: _____
Active spiritual practice: Y N P Stress involved with Significant relationship (1-10, 10 being most stress): ____
History of sexual, mental/emotional, physical abuse: Y N P

Allergies
List all known Allergies (food, drugs, environment): _____
_____

List All Surgeries & Hospitalizations, including date occurred: _____
_____
_____

Additional Information

Please list any additional information/topics which you believe is important we address during your office visit:

_____

_____

_____