New Patient Intake Form

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

Confidential Patient Information **Today's Date: ________________**

Patient Name: ____________________________________ Date of Birth: ________________

Address: _____________________________________ City: __________ State: _____ Zip: _______

Phone Number: _________________________ Email Address: ______________________________

Occupation**:** ___________________________________

How did you hear about us? ____

Were you referred by another physician or patient? ▢ Yes ▢ No

Name of referring patient/physician: ____

Emergency Contact: ___________________________ Relationship: ________________

Phone number: ___________________________ ______________________________________

What are your top three health concerns, in order of importance and how do they limit you the most.

1) _____________________ ____

2) _____________________ ____

3) _____________________ ____

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

Name and telephone number of Primary Care physician:____________________________________ .

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

X-Rays: __________________________________ HIV Test: ______________
MRI/Cat Scan: ____________________________ HCV: _________________
Ultrasounds: ______________________________ Last Dental Visit: _________________
Accidents: ________________________________ Last Eye Exam: __________________
TB Test: _____________________

Family History

Number of Children: _________ **Ages of Children** _____ _____ _____ _____ _____ _____

	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

Did you have any of the following: (Circle what applies)**: Disease (D), Get Immunized (I), or Neither (N):**

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

Any vaccination reactions: ____

Do you use any of the following?: Mark **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**)

Antacids: Y N P
Analgesics: Y N P
Smoking: Y N P
Coffee: Y N P
Soda Pop: Y N P
Alcohol: Y N P
Alcohol Addiction: Y N P
Any Alcohol Treatment: Y N P
Recreational Drugs: Y N P
Any Drug Addictions: Y N P

Steroids: Y N P
Laxatives: Y N P
Packs per day & number of years: __________
Cups per day if Yes/Past: ________________
Ounces per day if Yes/Past: ______________ ______________
How often & how much if Yes/Past:________________
Any Drug Treatment: Y N P ________________________

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

____

____

____

Review of Systems:

Height: _______ **Present Weight**: _______ **Weight one year ago**: _______ **Ideal Weight**: _______

Maximum weight and when: ______________ **Minimum weight as adult & when**: ______________ ________

REGARDING THE NEXT LONG SECTION: Please mark **(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: ▢ Yes ▢ No ▢ Past

Fatigue: ▢ Yes ▢ No ▢Past

If you have fatigue, when is it the worst? ▢ Morning ▢ Afternoon ▢ Evening

If you have fatigue, can you do what you need to during the day? ▢ Yes ▢ No

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

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

FEMALE

Age Period Began:			Period Frequency:	
How long period lasts:			Heavy menstruation:	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

Exercise:

Do you exercise? ▢ Yes ▢ No

If yes, what do you do for exercise? ____

How often and for how long? ____

Hobbies:

What do you do for fun? ____

Typical Day's Diet:

Breakfast:____

Snack:____

Lunch:____

Snack:____

Supper:____

Snack:____

Water/other drinks: ____

Sleep:

How many hours do you average per night?_________

If you wake up frequently, what is the reason? ____

Nightmares: Y N P

Must nap during the day: Y N P

Grind teeth: Y N P

Wake Refreshed: Y N P

Sleep walk: 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? ▢ Yes ▢ No

Do you use pesticides, herbicides or other chemicals around your home? ▢ Yes ▢ No _______________

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:

____
____
____