

New Patient Intake Form

Please take the time to fill out this questionnaire carefully. The information that you provide will assist me in forming a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

First Name \_\_\_\_\_ Middle Initial \_\_\_\_\_ Last Name \_\_\_\_\_  Male  Female  
 Date of Birth \_\_\_\_\_ Age \_\_\_\_\_  
 Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
 Home Phone \_\_\_\_\_ Work Phone \_\_\_\_\_ Cell \_\_\_\_\_  
 Emergency Contact: Name \_\_\_\_\_ Phone Number \_\_\_\_\_  
 Marital Status:  single  committed  married  divorced E-mail \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 How did you hear about us? \_\_\_\_\_  
 Current Physician: \_\_\_\_\_ Phone \_\_\_\_\_ may I contact? Yes  No

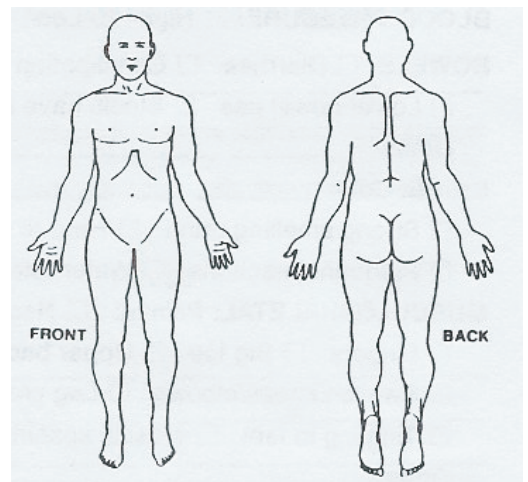
Main Complaint (symptoms, diagnosis, duration, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What makes your condition worse? (stress, fatigue, hunger, heat, certain foods, rainy days, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

What makes your condition better? (rest, movement, heat, cold, eating, crying, etc.)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Have you seen any other doctors for this conditions? Yes No  
 (If yes, please list doctor, prior interventions, and treatments)  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please mark areas of discomfort.



Current Medications/ Vitamins/ Herbs (use reverse side if necessary)

Name	Dosage	Duration	Reason
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Reported Symptoms

Name \_\_\_\_\_ Date \_\_\_\_\_

Please take the time to fill out this questionnaire carefully. The information that you provide will assist me in forming a complete health profile for you. Check symptoms you have experienced in the last year. Put a star in the box if you have had this in the past but you do not any longer. All of your answers are absolutely confidential. If you have any questions, please ask.

### General

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Poor Sleeping      | <input type="checkbox"/> Fatigue                        | <input type="checkbox"/> Fevers              |
| <input type="checkbox"/> Chills                  | <input type="checkbox"/> Night Sweats       | <input type="checkbox"/> Sweats Easily                  | <input type="checkbox"/> Tremors             |
| <input type="checkbox"/> Cravings                | <input type="checkbox"/> Weightloss/gain    | <input type="checkbox"/> Poor Balance                   | <input type="checkbox"/> Change in appetite  |
| <input type="checkbox"/> Bleed/ Bruise easily    | <input type="checkbox"/> Sudden energy drop | <input type="checkbox"/> Peculiar tastes/smells         | <input type="checkbox"/> Dental/ gum problem |
| <input type="checkbox"/> muscle weakness/fatigue | <input type="checkbox"/> Localized Weakness | <input type="checkbox"/> Strong thirst (hot/cold drink) |  |

### Skin and Hair

- |   |                                     |   |   |
|---|-------------------------------------|---|---|
| <input type="checkbox"/> Rashes             | <input type="checkbox"/> Ulceration | <input type="checkbox"/> Hives/ Allergic Dermatitis   | <input type="checkbox"/> Itching              |
| <input type="checkbox"/> Eczema/ Psoriasis  | <input type="checkbox"/> Dandruff   | <input type="checkbox"/> Loss of Hair                 | <input type="checkbox"/> Recent moles         |
| <input type="checkbox"/> Skin Discoloration | <input type="checkbox"/> Acne       | <input type="checkbox"/> Change in skin/ hair texture | <input type="checkbox"/> Face Flushing        |
| <input type="checkbox"/> Dry Skin           | <input type="checkbox"/> Warts      | <input type="checkbox"/> Fungal Infection             | <input type="checkbox"/> Weak or ridged nails |

### Head, Eyes, Ears, Nose and Throat

- |  |   |   |  |
|--|---|---|--|
| <input type="checkbox"/> Dizziness             | <input type="checkbox"/> Difficulty Swallowing        | <input type="checkbox"/> Migraines              | <input type="checkbox"/> Glasses           |
| <input type="checkbox"/> Eye Strain            | <input type="checkbox"/> Eye pain                     | <input type="checkbox"/> Poor Vision            | <input type="checkbox"/> Poor night vision |
| <input type="checkbox"/> Color Blindness       | <input type="checkbox"/> Cataracts                    | <input type="checkbox"/> Blurred Vision         | <input type="checkbox"/> Earaches          |
| <input type="checkbox"/> Ringing in ears       | <input type="checkbox"/> Poor hearing                 | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Sinus problems    |
| <input type="checkbox"/> Nose bleeds           | <input type="checkbox"/> Recurrent sore throat/ colds | <input type="checkbox"/> Grinding teeth         | <input type="checkbox"/> Facial pain       |
| <input type="checkbox"/> Sores on lips/ tongue | <input type="checkbox"/> Dental problems              | <input type="checkbox"/> Jaw clicks/ locks      | <input type="checkbox"/> Headaches         |

### Cardiovascular

- |   |  |   |                                    |
|---|--|---|------------------------------------|
| <input type="checkbox"/> Chest pain or pressure | <input type="checkbox"/> Irregular heart beat        | <input type="checkbox"/> Palpitations at rest | <input type="checkbox"/> Fainting  |
| <input type="checkbox"/> Cold hands/ feet       | <input type="checkbox"/> Swelling of the hands/ feet | <input type="checkbox"/> Blood Clots          | <input type="checkbox"/> Anemia    |
| <input type="checkbox"/> Shortness of breath    | <input type="checkbox"/> Varicose/ Spider Veins      | <input type="checkbox"/> High Blood Pressure  | <input type="checkbox"/> Dizziness |
| <input type="checkbox"/> Low Blood Pressure     | <input type="checkbox"/> Light headed                |   |                                    |

### Respiratory

- |  |  |  |  |
|--|--|--|--|
| <input type="checkbox"/> Cough/ Wheezing                 | <input type="checkbox"/> Coughing blood            | <input type="checkbox"/> Asthma                            | <input type="checkbox"/> Bronchitis          |
| <input type="checkbox"/> Pneumonia                       | <input type="checkbox"/> Pain with deep inhalation | <input type="checkbox"/> Tight sensation in chest          | <input type="checkbox"/> Difficulty inhaling |
| <input type="checkbox"/> Difficulty breathing lying down |  | <input type="checkbox"/> Production of phlegm- color _____ |  |

### Gastrointestinal

- |  |   |  |   |
|--|---|--|---|
| <input type="checkbox"/> Nausea              | <input type="checkbox"/> Vomiting             | <input type="checkbox"/> Diarrhea                        | <input type="checkbox"/> Constipation       |
| <input type="checkbox"/> Gas                 | <input type="checkbox"/> Belching             | <input type="checkbox"/> Black stools                    | <input type="checkbox"/> Blood in stool     |
| <input type="checkbox"/> Indigestion         | <input type="checkbox"/> Bad breath           | <input type="checkbox"/> Rectal pain                     | <input type="checkbox"/> Hemorrhoids        |
| <input type="checkbox"/> Bloating            | <input type="checkbox"/> Chronic laxative use | <input type="checkbox"/> Loose stools (less than 2x/day) | <input type="checkbox"/> Abdominal pain     |
| <input type="checkbox"/> Changes in appetite | <input type="checkbox"/> Acid reflux/ GERD    | <input type="checkbox"/> Hernia                          | <input type="checkbox"/> Excessive appetite |

Health History: Name \_\_\_\_\_ Date \_\_\_\_\_

Genito- Urinary

- |  |   |  |  |
|--|---|--|--|
| <input type="checkbox"/> Pain on urination                       | <input type="checkbox"/> Frequent Urination | <input type="checkbox"/> Blood in Urine          | <input type="checkbox"/> Urgent urination          |
| <input type="checkbox"/> Unable to hold urine                    | <input type="checkbox"/> Kidney stones      | <input type="checkbox"/> Scanty flow             | <input type="checkbox"/> Copious flow              |
| <input type="checkbox"/> Impotence                               | <input type="checkbox"/> Sores on genitals  | <input type="checkbox"/> Urinary tract infection | <input type="checkbox"/> Burning urination         |
| <input type="checkbox"/> Premature ejaculation                   | <input type="checkbox"/> Decreased libido   | <input type="checkbox"/> Prostatitis             | <input type="checkbox"/> Dribbling after urination |
| <input type="checkbox"/> Nocturnal emission                      | <input type="checkbox"/> Pain in testicles  | <input type="checkbox"/> Herpes                  | <input type="checkbox"/> Infections                |
| <input type="checkbox"/> Night urination. . . . How Often? _____ | <input type="checkbox"/> Excessive libido   |  |  |

Gynecological/ Reproductive

- |   |   |                                     |
|---|---|-------------------------------------|
| <input type="checkbox"/> Difficult/ Painful intercourse | <input type="checkbox"/> Ovarian cysts              | Age of first menses _____           |
| <input type="checkbox"/> Vaginal dryness                | <input type="checkbox"/> Endometriosis              | Date of last menses _____           |
| <input type="checkbox"/> Vaginal sores                  | <input type="checkbox"/> Uterine Fibroids           | Date of last Pelvic/ PAP _____      |
| <input type="checkbox"/> Vaginal discharge              | <input type="checkbox"/> Fibrocystic breast tissue  | Number of pregnancies _____         |
| <input type="checkbox"/> Infertility                    | <input type="checkbox"/> Polycystic Ovarian Disease | Number of Ectopic pregnancies _____ |
| <input type="checkbox"/> Irregular Menstruation         | <input type="checkbox"/> PMS                        | Number of live births _____         |
| <input type="checkbox"/> Do you practice birth control? | <input type="checkbox"/> Painful Menstruation       | Number of miscarriages _____        |
| If so, list type _____                                  |   | Number of abortions _____           |

Neuropsychological

- |   |  |  |   |   |
|---|--|--|---|---|
| <input type="checkbox"/> Seizures             | <input type="checkbox"/> Loss of Balance       | <input type="checkbox"/> anxiety       | <input type="checkbox"/> Easily susceptible to stress | <input type="checkbox"/> Vertigo/ Dizziness |
| <input type="checkbox"/> Lack of coordination | <input type="checkbox"/> Poor memory           | <input type="checkbox"/> panic attacks | <input type="checkbox"/> Anger                        | <input type="checkbox"/> Depression         |
| <input type="checkbox"/> Manic-Depression     | <input type="checkbox"/> Bad Temper/ irritable | <input type="checkbox"/> Nervousness   | <input type="checkbox"/> ADD/ ADHD                    | <input type="checkbox"/> Over thinking      |

Musculoskeletal

- |                                    |   |  |   |                                       |
|------------------------------------|---|--|---|---------------------------------------|
| <input type="checkbox"/> Neck Pain | <input type="checkbox"/> Shoulder Pain  | <input type="checkbox"/> Hand/Wrist pain | <input type="checkbox"/> Carpal Tunnel        | <input type="checkbox"/> Rotator Cuff |
| <input type="checkbox"/> Knee pain | <input type="checkbox"/> Sprains/ Strains   | <input type="checkbox"/> Sciatica        | <input type="checkbox"/> Foot/ Ankle Pain     | <input type="checkbox"/> Numbness     |
| <input type="checkbox"/> Hip Pain  | <input type="checkbox"/> Muscle pain  | <input type="checkbox"/> Muscle weakness | <input type="checkbox"/> Lower body weak/sore | <input type="checkbox"/> Tendonitis   |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Low <input type="checkbox"/> Middle <input type="checkbox"/> Upper |  |   |                                       |

Allergies:

Significant Trauma (physical or emotional)

Past Hospitalizations/ Illnesses/ Accidents (please list)

Date

Please check any condition that applies to you or your immediate family. Put an (\*) You, (F) Father, (M) Mother, (S) Sister, (B) Brother, (GM) Grandmother, (GF) Grandfather

- |  |  |                                       |  |                                       |
|--|--|---------------------------------------|--|---------------------------------------|
| <input type="checkbox"/> AIDS/ HIV           | <input type="checkbox"/> Alcoholism    | <input type="checkbox"/> Allergies    | <input type="checkbox"/> Anemia        | <input type="checkbox"/> Arthritis    |
| <input type="checkbox"/> Asthma              | <input type="checkbox"/> Breast Cancer | <input type="checkbox"/> Colon Cancer | <input type="checkbox"/> Depression    | <input type="checkbox"/> Diabetes     |
| <input type="checkbox"/> Drug Abuse          | <input type="checkbox"/> Epilepsy      | <input type="checkbox"/> Glaucoma     | <input type="checkbox"/> Heart Attack  | <input type="checkbox"/> Hepatitis    |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> IBS           | <input type="checkbox"/> Infertility  | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Lyme Disease |
| <input type="checkbox"/> Mental Illness      | <input type="checkbox"/> Migraines     | <input type="checkbox"/> Pneumonia    | <input type="checkbox"/> Stroke        | <input type="checkbox"/> Suicide      |
| <input type="checkbox"/> Thyroid imbalance   | <input type="checkbox"/> Ulcers        |                                       |  |                                       |

Lifestyle/ Self-Care

Do you allow time to relax? Yes  No  If yes, how? \_\_\_\_\_

Please rate the following areas:

	great	good	ok	poor	bad
Family.....	5.....	4.....	3.....	2.....	1.....
Partner.....	5.....	4.....	3.....	2.....	1.....
Libido.....	5.....	4.....	3.....	2.....	1.....
Self.....	5.....	4.....	3.....	2.....	1.....
Work.....	5.....	4.....	3.....	2.....	1.....
Exercise.....	5.....	4.....	3.....	2.....	1.....
Spirituality.....	5.....	4.....	3.....	2.....	1.....

Do you use the following?

- Cigarettes \_\_\_\_\_ pack/ day
- Alcohol \_\_\_\_\_ drinks/ week
- Recreational Drugs \_\_\_\_\_
- Coffee \_\_\_\_\_ cups/ day
- Tea \_\_\_\_\_ cups/ day

Exercise

Days per week \_\_\_\_\_ Length of Activity \_\_\_\_\_ Type of Activity \_\_\_\_\_

Diet

Please list some of your favorite foods \_\_\_\_\_  
\_\_\_\_\_

How many meals do you eat per day? \_\_\_\_\_ When is your biggest meal? \_\_\_\_\_

Do you eat when you are worried or rushed? Yes  No  Do you frequently eat in between meals Yes  No

How much liquid do you drink per day? \_\_\_\_\_ cups What types (ie. water, soda, beer)? \_\_\_\_\_

Do you eat raw fruits and vegetables at least twice per day? Yes  No

Do you eat meat products? Yes  No  Dairy products? Yes  No  Soy products? Yes  No

Do you eat when you're not hungry? Yes  No  Do you eat until you feel full? Yes  No

"Typical" Breakfast \_\_\_\_\_  
\_\_\_\_\_

Lunch \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Dinner \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Devices: Please mark those that you use.

- Pacemaker
- Contact Lenses
- Hearing Aid
- Artificial Limb
- Birth Control
- Eyeglasses
- Dentures
- Brace (neck, arm, back)