



NEW PATIENT INTAKE FORM

Date: _____

New Patient Information

Name: _____ DOB: ___/___/___ Age: _____
(Last) (First) (Gender)

Address: _____ City: _____ St: _____ Zip: _____

Home Phone: (____) _____ Cell Phone: (____) _____ Work Phone: (____) _____

Permission to leave detailed messages regarding your medical care at: ___home ___work ___cell

Social Security# _____ Email Address: _____

If minor, name of parent/guardian(s) _____

Address: _____ Phone: (____) _____

Additional Patient Information

Occupation: _____ Employer/Business: _____

Marital Status (circle): Single Married Partnered Separated Divorced Widow(er)

Children: Y N Number of children: _____ Age(s): _____

Emergency Contact: _____ Relationship: _____

Emergency Contact Phone: (____) _____

Do you have a primary care physician? Y N

If yes, Physician's Name: _____ Physician's Phone: (____) _____

Address: _____ City: _____ St: _____ Zip: _____

Referral Information

How did you hear about us? _____

Whom may we thank for referring you? _____

Adult Medical History

Please list your health concerns, in order of importance:

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

Entered by: _____

Family History

	Mother	Father	Siblings	Grandparents	Spouse	Children
Age, if living:	_____	_____	_____	_____	_____	_____
If deceased, cause: and age of death	_____	_____	_____	_____	_____	_____
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
Tuberculosis:	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
Arthritis:	Y N	Y N	Y N	Y N	Y N	Y N
Thyroid Problems:	Y N	Y N	Y N	Y N	Y N	Y N
Alcoholism/Addiction:	Y N	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N	Y N

Personal History

List all surgeries, hospitalizations, or major accidents including date occurred:

- 1) _____ 4) _____
 2) _____ 5) _____
 3) _____ 6) _____

What is your blood type: _____

Have you ever had any infectious disease from which you never fully recovered? _____

Ever taken antibiotics for a prolonged period of time? Y N For what condition? _____

Current Medications

Prescription Medications	Dose	Since	Adverse effects?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Current Supplements and/or Over the Counter Medications

Supplement/OTC Medication	Dose, Frequency	Supplement/OTC Medication	Dose, Frequency
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Do you have difficulty swallowing pills? Y N

Do you use any of the following?

Cigarettes or tobacco: Y N How much?: _____ For how long? _____
 Marijuana or other drugs: Y N Frequency: _____
 Alcohol: Y N Drinks per day/week? _____ Type of alcohol: _____
 History of alcohol addiction: Y N History of alcohol treatment? Y N
 History of drug addiction: Y N History of drug treatment? Y N
 History of eating disorder? Y N

Are you allergic to any medications? If so, which one(s) and what is your reaction? _____

Review of Systems:

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

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

GENERAL

Fatigue	Y N P	Poor Sleep	Y N P
Frequent Colds, illness	Y N P	Night Sweats	Y N P
Poor Memory	Y N P	Fainting	Y N P
Poor Concentration	Y N P	Dizziness	Y N P

SKIN & HAIR

Rash	Y N P	Color Change	Y N P
Hives	Y N P	Skin Cancer	Y N P
Psoriasis/Eczema	Y N P	Itchy	Y N P
Dry Skin	Y N P	Warts, moles	Y N P
Weak, brittle nails	Y N P	Excessive Perspiration	Y N P
Dry Hair	Y N P	Hair Loss	Y N P

HEAD & NECK

Headaches	Y N P	Head Injury	Y N P
Migraines	Y N P	Dandruff	Y N P
Swollen Glands	Y N P	Neck Stiffness	Y N P

EYES & EARS

Blurry Vision	Y N P	Glaucoma	Y N P
Itchy	Y N P	Cataracts	Y N P
Dry	Y N P	Discharge	Y N P
Watery	Y N P	Styes	Y N P
Sensitive to Light	Y N P	Dark circles under eyes	Y N P
Ear infections	Y N P	Ringing in Ears	Y N P
Hearing Loss	Y N P	Excessive ear wax	Y N P

NOSE, MOUTH, & THROAT

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
Sinusitis	Y N P	Toothache	Y N P
Canker Sores	Y N P	Cold Sores	Y N P
Loss of taste/smell	Y N P	Bleeding Gums	Y N P
Dry Mouth	Y N P	Hoarse Voice	Y N P
Sore throat	Y N P	Cavities	Y N P

RESPIRATORY

Cough	Y N P	Asthma	Y N P
Shortness of Breath with exertion	Y N P	Bronchitis	Y N P
Shortness of Breath lying down	Y N P	Pneumonia	Y N P
Wheezing	Y N P	Tuberculosis	Y N P
		Chemical fume exposure	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
Irregular Heart Beat	Y N P	Palpitations	Y N P
Swollen feet or ankles	Y N P	Chest Pain	Y N P
Varicose Veins	Y N P	Leg Pain with walking	Y N P

GASTROINTESTINAL

Heartburn	Y N P	Changes in BM frequency	Y N P
Indigestion	Y N P	Constipation	Y N P
Bloating	Y N P	Diarrhea	Y N P
Nausea	Y N P	Hemorrhoids	Y N P
Vomiting	Y N P	Ulcer	Y N P
Change in Appetite	Y N P	Mucous in stool	Y N P
Pancreatitis	Y N P	Blood in stool	Y N P
Irritated by fatty/greasy food	Y N P	Use antacids	Y N P
Difficulty Swallowing	Y N P	Feel bad if skip a meal	Y N P
Liver Disease	Y N P	Excessive gas	Y N P
Gall Bladder Disease	Y N P	Anal Itching	Y N P
# Bowel movements/day_____			

URINARY TRACT

Frequent Infections	Y N P	Increased Urinary Frequency	Y N P
Incontinence	Y N P	Kidney Stones	Y N P
Urgency	Y N P	Discharge, Blood w/ Urination	Y N P
Pain with Urination	Y N P	Frequent urination at night	Y N P

MUSCULOSKELETAL

Loss of Strength	Y N P	Pain	Y N P
Stiffness of joints	Y N P	Arthritis	Y N P
Tremors	Y N P	Leg Cramps	Y N P

Swelling of joints Y N P

Muscle Pain Y N P

NERVOUS SYSTEM

Paralysis Y N P
 Tingling/Numbness Y N P
 Seizures Y N P

Sciatica Y N P
 Carpal Tunnel Syndrome Y N P
 Fainting Y N P

MENTAL/EMOTIONAL

Depression Y N P
 Anxiety Y N P
 Suicidal Thoughts Y N P
 Panic Attacks Y N P

Anger/irritability Y N P
 High-strung/tense Y N P
 Fear/ phobias Y N P
 Psychiatric Hospitalization Y N P

FEMALE HEALTH

Age of first period _____
 # Days of flow _____
 Length of cycle _____
 # of Pregnancies _____
 # of children _____
 Miscarriages/abortions _____
 Date of last PAP _____
 History of Abnormal PAP Y N P
 When _____
 Diagnosis _____
 PMS Y N P
 Symptoms _____
 Breast Tenderness Y N P
 Heavy menstrual flow Y N P
 Irregular Periods Y N P

Hysterectomy Y N P
 Reason: _____
 Menopausal since what age _____
 Use of hormones Y N P
 Type: _____
 Low Libido Y N P
 Difficulty with conception Y N P
 Pain with intercourse Y N P
 Ovarian Cyst Y N P
 Fibroids Y N P
 Endometriosis Y N P
 Vaginitis Y N P
 STD Y N P
 Do you do self-breast exams Y N P
 DEXA Bone Scan Y N P
 Mammography Y N P

Current birth control method _____

Have you ever used hormonal birth control or an IUD? When and for how long? _____

MALE HEALTH

Testicular pain/swelling Y N P
 Hernia Y N P
 Discharge from penis Y N P
 Impotence Y N P

STD Y N P
 Prostate disease/symptoms Y N P
 Low Libido Y N P
 Weakness or forking of stream with urination Y N P

Exercise

How often do you exercise? _____ What type of exercise? _____

For how long? _____

Sleep

How many hours per night? _____ Quality of sleep? _____

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 History

Enjoy work: Y N P Hours worked per week: _____

Active spiritual practice: Y N P

Quality of significant Relationship: _____

History of sexual abuse: Y N P

Stress Level: _____

What activities do you enjoy doing: _____

How committed are you towards making changes in your health: Little Moderate Very

Typical Day's Diet

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

How much per day/week: Coffee _____ Energy Drinks _____ Black Tea _____ Soda _____

Water _____ tap filtered bottled

List all known Allergies (food, environmental): _____

Foods craved: _____

Foods avoided: _____

Thank you for your patience in completing this form.