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New Patient Intake Form

___________________________________ ______________ ________ ____________
Name Date of Birth Age Gender

Please list in order of importance your health concerns that bring you in:

1. ____
2. ____
3. ____
4. ____
5. ____

Who is your primary care physician

____

Date of last blood work and the physician who ordered it (if different from PCP):

____

ALLERGIES TO?

DRUGS/MEDICATIONS____

FOODS____

OTHER ____

LIST ALL HOSPITALIZATIONS, SURGERIES (PLEASE SPECIFY THE DATE OCCURRED):

____

____

____

____

Please note why and when you had each of the following:

XRAYS________________________ULTRASOUNDS______________________________________

MRI/CATS________________________ ACCIDENTS______________________________________

LAST DENTAL VISIT ____

LAST EYE EXAM ____

LAST MAMMOGRAM or THERMOGRAPHY ____

List ALL prescription medications you are taking, include dosage:

____

____

____

____

List ALL nutritional supplements/vitamins and/or herbs you are taking, please include dosage, how often, and brand (if known):

____

____

____

____

Did you have the following , please circle which applies to you
*__D__isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**) Don't know (?) :

Measles: D I N ? **Chicken Pox**: D I N ? **Mumps**: D I N ? **Rubella**: D I N ?

Tetanus: D I N ? **Whooping Cough**: D I N ? **Hemophilus (Hib)**: D I N ? **Hepatits B**: D I N ?

German Measles: D I N ?

Any vaccination reactions:

____

____

____

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following, if yes please specify:

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 NP:____

Recreational Drugs: Y N P: ____

Any Drug Addictions: Y N P: ____

Any Drug Treatment: Y N P: ____

Family History:

	Father	Mother	Siblings	Grand-parents	Spouse	Children
Age if living						
Age when died						
Reason for death						
Cancer history, if yes, type						
High blood pressure	Y N	Y N	Y N	Y N	Y N	Y N
obesity	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

Review of Systems:

Present Weight: ________________Weight one year ago:____________ Height: _____________
Maximum weight & when: _________________Minimum weight & when: ___________
Ideal Weight: _____________________

***FOR THE NEXT SECTION**: Circle (**Y**) if you have the problem **NOW**, (**N**) if you've **NEVER** had the problem, (**P**) if it is a **PAST** problem*

Good Energy: Y N P
Fatigue: Y N P
Exercise:
How often do you exercise________________________
What type of exercise ____________________________
For how long __________________________________
Hobbies: _______________________________________

Sleep:
Hours per night______ Stay asleep: Y N P Fall asleep easily: Y N P
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 a 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? ________________
____
Do you eat conventionally grown produce and food? _________________________________
Do you have mercury amalgams? ____

Social Life:
Do you enjoy job and/or career: Y N P   Hours worked per week: __________
Highest Level of Education: ___________________________
Active spiritual practice: Y N P: ________________________
Quality of significant relationship: ______________________
History of sexual, mental/emotional, physical abuse: Y N P
If so, at what age and by whom: ________________________

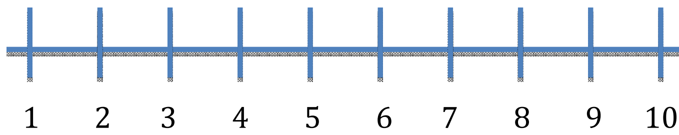
What is your greatest health concern: ____

____

How does your health concern(s) limit you: ______________________________________

____

What is your commitment level toward getting better? (On a scale from 1 -10, 10 being the highest level of commitment, 1 being no commitment. Mark an X where you currently are:



1 2 3 4 5 6 7 8 9 10

Where are you on your health journey? ____

____

____

____

____

____

What is your commitment to optimal health? ____

____

____

____

____

____

How did you hear about us; if a referral, please specify who? ______________________________

____

Skin		Eyes	
Rash	Y N P	Dry/Watery eyes	Y N P
Hives	Y N P	Double vision	Y N P
Psoriasis/Eczema	Y N P	Glaucoma or cataracts	Y N P
Dry	Y N P	Strain/itchy	Y N P
Cancer	Y N P	Blurry vision	Y N P
Color change	Y N P	Styes	Y N P
Lump	Y N P	Discharge	Y N P
Itchy	Y N P	Dark under eyes	Y N P
Warts/moles/lesions	Y N P	**Head**	
Perspiration	Y N P	Headaches	Y N P
Mouth		Migraines	Y N P
Canker sores	Y N P	Dandruff	Y N P
Cold sores	Y N P	Oily or dry hair	Y N P
Dentures	Y N P	Head injury	Y N P
Loss of taste	Y N P	Hair loss	Y N P
Gum disease	Y N P	**Neck**	
Cavities	Y N P	Stiffness	Y N P
Sore throat	Y N P	Full movement	Y N P
Hoarseness	Y N P	Swollen Glands	Y N P
		Pain and or tension	Y N P

Cardiovascular		**Respiratory**	
high blood pressure	Y N P	Cough	Y N P
low blood pressure	Y N P	Shortness of breath with acticity	Y N P
arrhythmia	Y N P	Shortness of activity while sitting	Y N P
murmurs	Y N P	Shortness of breath while lying down	Y N P
palpitations	Y N P	Wheezing	Y N P
chest pain	Y N P	asthma	Y N P
rheumatic fever	Y N P	painful breathing	Y N P
edema	Y N P	pneumonia	Y N P
		bronchitis	Y N P
Gastrointestinal		TB	Y N P
Heartburn	Y N P		
Indigestion	Y N P	**Urinary Tract**	
Nausea	Y N P	frequent urination	
Vomiting	Y N P	frequent infections	
belching	Y N P	urgency	
bloating	Y N P	pain with urination	
Bowel movements per day	Y N P	kidney stones	
diarrhea	Y N P	blood or discharge	
constipation	Y N P		
Hemorrhoids	Y N P	**MALES only**	Y N P
Pancreatitis	Y N P	testicular pain or swelling	Y N P
Liver disease	Y N P	hernia	Y N P
Gallbladder disease	Y N P	discharge	Y N P
Ulcer	Y N P	impotency	Y N P
change in appetite	Y N P	sexually activity	Y N P
flatulence	Y N P	STI (aka STD)	Y N P
		Prostate diseases/symptoms	Y N P

Females Only

age period began	
length of cycle	
length of period	
Menstrual cramping	Y N P
PMS	Y N P
Heavy menstrual bleeding	Y N P
menstrual pain	Y N P
food cravings	Y N P
how many pregnancies	Y N P
how many births	Y N P
miscarriages	Y N P
abortions	Y N P
Last pap smear	Y N P
abnormal pap smear	Y N P
STI (aka STD)	Y N P
sexually active	Y N P
birth control use	Y N P
age of Menopause	Y N P
vaginal dryness	Y N P
pain with intercourse	Y N P
any hormones used	Y N P
healthy libido	
vaginitis	
Last DEXA scan	
last Mammogram	