

PATIENT INTAKE FORM

Name _____

Date _____

REFERRED BY _____

CHIEF COMPLAINT _____

What are your expectations after treatment in this clinic? _____

Past Medical History (Include Dates)

Significant Illnesses Cancer _____ Diabetes _____ High Blood Pressure _____ Heart Disease _____

Hepatitis _____ Rheumatic Fever _____ Thyroid Disease _____ Seizure _____

Other _____

Surgeries _____

Significant Trauma (auto accidents, falls, emotional, etc.) _____

Birth History (prolonged labor, forceps delivery, etc) _____

Allergies (drugs, chemicals, foods) _____

Prescription Medications _____

Supplements (list all) _____

Occupational stresses (chemical, physical, psychological, etc.) _____

Exercise _____

Average Daily Diet

Morning

Afternoon

Evening

Habits Cigarettes # _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Drugs _____ Sugar _____ Salt _____

Other _____

Family Medical History Diabetes _____ Cancer _____ High Blood Pressure _____ Heart Disease _____ Stroke _____ Seizures

_____ Asthma _____ Alcoholism _____ Other _____

Notes _____

Social History Married _____ Divorced _____ Single _____ Children (how many) _____ Ages _____

Occupation _____

General

Poor Appetite	Heavy Appetite	Poor Sleep	Heavy Sleep	Insomnia
Fatigue	Tremors	Vertigo	Cold Hands	Cold Feet
Cold Back	Cold Abdomen	Fevers	Chills	Night Sweats
Sweat Easily	Change/appetite	Localized Weakness	Poor Coordination	Cravings
Sudden drop in energy at (time) _____		Strong thirst (cold/hot drinks) _____		
Peculiar Taste/Smells _____		Bleed or bruise easily (where) _____		

Skin and Hair

Rashes _____ Ulcerations _____ Hives _____ Itching _____ Eczema _____

Acne _____ Dandruff _____ Hair Loss _____

Change in hair/skin texture _____

Other hair or skin problems _____

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Head, Eyes, Ears, Nose and Throat

Dizziness Concussion Migraines Glasses Eye Strain Eye
Pain Poor Vision Cataracts Color Blindness Night Blindness Blurry
Vision Earaches Poor Hearing Ringing in Ears Sinus Problems
Nose Bleeds Dry Throat Dry Mouth Copious Saliva Mucous
Jaw Clicks Teeth Problems Grinding Teeth Gum Problems Facial Pain
Spots in Eyes Recurrent Sore Throats _____/Month Sores/Lips Sores/Tongue
Headaches(where/when) _____
Other Head or Neck Problems _____

Dental

Silver Fillings Root Canals Crowns Periodontal Disease Tooth Decay Braces Bridges

Cardiovascular

Chest Pain High Blood Pressure Low Blood Pressure Fainting Dizziness
Irregular Heartbeat Blood Clots Phlebitis Cold Hands Cold Feet
Swelling Hands Swelling Feet
Other: _____

Respiratory

Cough Coughing Blood Asthma Bronchitis Pneumonia
Difficult Breathing lying down Production of phlegm/color _____
Other lung problems: _____

Gastrointestinal

Nausea Vomiting Diarrhea Bowel Movements
Gas Belching Black Stools Frequency _____
Bad Breath Rectal Pain Hemorrhoids Color _____
Constipation Bloody Stools Sensitive Abdomen Odor _____
Pain or Cramps Laxative Use: _____/week Type _____ Texture _____

Genitourinary/Prostate

Pain/Urination Frequent Urination Blood in Urine Kidney Stones
Impotency Venereal Disease Urgency to Urinate Unable to hold urine
Wake up to urinate(how often) _____/night What Time? _____
Other G/U Problems: _____

Pregnancy/Gynecology

Irregular Periods Clots Vaginal Discharge Vaginal Sores Breast Lumps
Intramenstrual Spotting (when) _____ IUD use Douche
Pregnancies(how many) _____ Number of Births _____ Premature Births _____ Miscarriages _____ Age at first Menses _____
Period (cycle days) _____ Period (duration days) _____ Flow(describe) _____
PMS (describe) _____
Menstrual Cramps None Mild Moderate Severe Menopause (when) _____
Birth Control (type and duration) _____
Sexually Transmitted Disease Gonorrhea HPV HIV Chlamydia Hepatitis
Last Pap Smear _____ Abnormal Pap (when) _____
Last Mammogram _____ Self-Breast Exams (how often) _____

Musculoskeletal

Neck Pain Muscle Pains Back Pain Joint Pain
Describe Location of Pain _____ Other
joint or bone problems _____

Neuropsychological

Seizures Areas of numbness Poor Memory Concussion Depression
Anxiety Easily Stressed Bad Temper Counseling Suicide Attempt
Other Neurological or Psychological Problems: _____