

## INITIAL INTAKE FORM

Patient Name: _____	
Age: _____	Birth Date: ____/____/____ Sex: _____ SSN: _____ - _____ - _____
Address: _____	
City: _____	State: _____ Zip _____
Telephone (Day): _____	
Telephone (Night): _____	
Telephone (Mobile): _____	
Email Address: _____	
Occupation: _____	

### **Main Complaint**

Please identify the major health concerns for which you are seeking help with in order severity and for how long you have had each problem.

1. \_\_\_\_\_ How long? \_\_\_\_\_
2. \_\_\_\_\_ How long? \_\_\_\_\_
3. \_\_\_\_\_ How long? \_\_\_\_\_
4. \_\_\_\_\_ How long? \_\_\_\_\_
5. \_\_\_\_\_ How long? \_\_\_\_\_

How would you rate the quality of your life (1=very poor, 10=excellent)? 1 2 3 4 5 6 7 8 9 10

To what extent do these problems interfere with your daily activities and effect your quality of life? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your goals in coming to our office? \_\_\_\_\_  
\_\_\_\_\_

Have you been given a diagnosis for these problems? \_\_\_\_\_  
\_\_\_\_\_

What other treatments have you tried and what has been your response? \_\_\_\_\_  
\_\_\_\_\_

## General Information

Who referred you to us? \_\_\_\_\_ Phone: \_\_\_\_\_  
Who is your primary health care provider/MD? \_\_\_\_\_ Phone: \_\_\_\_\_  
In an emergency notify: \_\_\_\_\_ Phone: \_\_\_\_\_

## Personal Medical History

Illnesses: \_\_\_\_\_  
\_\_\_\_\_

Surgeries: \_\_\_\_\_  
\_\_\_\_\_

Significant Trauma (i.e. motor vehicle accidents, falls...) \_\_\_\_\_  
\_\_\_\_\_

Do you or have you ever had any infectious disease? \_\_\_\_\_. If so please describe: \_\_\_\_\_  
\_\_\_\_\_

Medicines (Please list all medications, herbs, vitamins, and over the counter drugs you are currently taking):  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Allergies/Sensitivities: Please list any foods, drugs, medications, or environmental factors which you are sensitive or allergic to: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Do you have allergic reactions to any oils, lotions, ointments, latex, or other substances applied to your skin?  
If so please describe: \_\_\_\_\_  
\_\_\_\_\_

### Significant Illnesses:

- |  |                                      |   |
|--|--------------------------------------|---|
| <input type="checkbox"/> Cancer              | <input type="checkbox"/> Diabetes    | <input type="checkbox"/> Hepatitis            |
| <input type="checkbox"/> Thyroid Disease     | <input type="checkbox"/> Seizures    | <input type="checkbox"/> Rheumatic Fever      |
| <input type="checkbox"/> Heart Disease       | <input type="checkbox"/> Stroke      | <input type="checkbox"/> Addictive Disorders  |
| <input type="checkbox"/> Food Allergies      | <input type="checkbox"/> Allergies   | <input type="checkbox"/> Respiratory Problems |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> HIV or AIDS | <input type="checkbox"/> Mental Illness       |
| <input type="checkbox"/> Other: _____        |                                      |   |

Habits:	Heavy	Moderate	Light	None
Exercise	_____	_____	_____	_____
Alcohol	_____	_____	_____	_____
Caffeine	_____	_____	_____	_____
Soft Drinks	_____	_____	_____	_____
Sugar Consumption	_____	_____	_____	_____
Tobacco	_____	_____	_____	_____
Fast/Junk Food	_____	_____	_____	_____
Recreational Drugs	_____	_____	_____	_____

## Family Medical History

Check All Applicable	Mother	Father	Sisters	Brothers	Spouse	Children
Current Age						
Arthritis						
Asthma						
Allergies						
Autoimmune Disease						
Back pain						
Cancer						
Constipation						
Diarrhea						
Diabetes						
Digestive Disorders						
Emotional Problems						
Epilepsy						
Headaches/Migraines						
Heart Disease						
High Blood Pressure						
Insomnia						
Kidney Disease						
Liver Disorders						
Reflux						
Stress/Anxiety						
Other						

If any of the above are deceased, what was the cause? \_\_\_\_\_

Childhood health: \_\_\_\_\_

### General (please check all that apply)

- |  |  |  |
|--|--|--|
| <input type="checkbox"/> Poor Appetite           | <input type="checkbox"/> Weakness              | <input type="checkbox"/> Sudden Energy Drops         |
| <input type="checkbox"/> Hearing Loss            | <input type="checkbox"/> Fevers                | <input type="checkbox"/> Particular Tastes or Smells |
| <input type="checkbox"/> Easy to Bleed or Bruise | <input type="checkbox"/> Sweat Easily          | <input type="checkbox"/> Fatigue                     |
| <input type="checkbox"/> Strong Thirst           | <input type="checkbox"/> Poor Sleep            | <input type="checkbox"/> Chills                      |
| <input type="checkbox"/> Tremors                 | <input type="checkbox"/> Poor Balance          | <input type="checkbox"/> Weight Loss                 |
| <input type="checkbox"/> Night Sweats            | <input type="checkbox"/> Cravings              | <input type="checkbox"/> Weight Gain                 |
| <input type="checkbox"/> Changes in Appetite     | <input type="checkbox"/> Puffiness or Swelling | <input type="checkbox"/> Other: _____                |

## **Skin & Hair**

- |  |                                     |                                       |
|--|-------------------------------------|---------------------------------------|
| <input type="checkbox"/> Rashes                  | <input type="checkbox"/> Itching    | <input type="checkbox"/> Dandruff     |
| <input type="checkbox"/> Skin Ulcers             | <input type="checkbox"/> Eczema     | <input type="checkbox"/> Hair Loss    |
| <input type="checkbox"/> Hives                   | <input type="checkbox"/> Pimples    | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Changes in Hair Texture | <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Chills       |

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

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Glasses                | <input type="checkbox"/> Poor Vision           |
| <input type="checkbox"/> Cataracts           | <input type="checkbox"/> Ear Ringing            | <input type="checkbox"/> Sinus Problems        |
| <input type="checkbox"/> Toothache           | <input type="checkbox"/> Teeth Problems         | <input type="checkbox"/> Taste/Smell Problems  |
| <input type="checkbox"/> Headaches           | <input type="checkbox"/> Concussions            | <input type="checkbox"/> Eye Strain            |
| <input type="checkbox"/> Night Blindness     | <input type="checkbox"/> Blurry Vision          | <input type="checkbox"/> Poor Hearing          |
| <input type="checkbox"/> Nose Bleeds         | <input type="checkbox"/> Facial Pain            | <input type="checkbox"/> Jaw Click             |
| <input type="checkbox"/> Migraines           | <input type="checkbox"/> Eye Pain               | <input type="checkbox"/> Color Blindness       |
| <input type="checkbox"/> Ear Aches           | <input type="checkbox"/> Spots in Front of Eyes | <input type="checkbox"/> Recurrent Sore Throat |
| <input type="checkbox"/> Lip or Tongue Sores | <input type="checkbox"/> Decreased Hearing      | <input type="checkbox"/> Floaters              |

## **Cardiovascular**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Low Blood Pressure | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Cold Hands or Feet  | <input type="checkbox"/> Blood Clots        | <input type="checkbox"/> Palpitations        |
| <input type="checkbox"/> Swelling of Hands   | <input type="checkbox"/> Swelling of Feet   | <input type="checkbox"/> Chest Pain          |
| <input type="checkbox"/> Phlebitis           | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Light Headedness    |

## **Respiratory**

- |                                 |  |   |
|---------------------------------|--|---|
| <input type="checkbox"/> Cough  | <input type="checkbox"/> Bronchitis        | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> Phlegm | <input type="checkbox"/> Coughing up Blood | <input type="checkbox"/> Pneumonia            |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Painful Breathing | <input type="checkbox"/> Easily Winded        |

## **Gastro-Intestinal**

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Nausea               | <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea         |
| <input type="checkbox"/> Bad Breath           | <input type="checkbox"/> Ulcers       | <input type="checkbox"/> Abdominal Pain   |
| <input type="checkbox"/> Chronic Laxative Use | <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Intestinal Gas   |
| <input type="checkbox"/> Indigestion          | <input type="checkbox"/> Rectal Pain  | <input type="checkbox"/> Belching         |
| <input type="checkbox"/> Blood in Stools      | <input type="checkbox"/> Hemorrhoids  | <input type="checkbox"/> Loss of Appetite |

## **Urology**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Painful Urination      | <input type="checkbox"/> Urgency to Urinate | <input type="checkbox"/> Unable to Hold Urine     |
| <input type="checkbox"/> Decrease in Urine Flow | <input type="checkbox"/> Frequent Urine     | <input type="checkbox"/> Blood in Urine           |
| <input type="checkbox"/> Cloudy Urine           | <input type="checkbox"/> Kidney Stones      | <input type="checkbox"/> Genital Sores            |
| <input type="checkbox"/> S.T.D.s                | <input type="checkbox"/> Pain in Groin Area | <input type="checkbox"/> Frequent Night Urination |

## **Neuro-Psychological**

- |                                       |   |                                      |
|---------------------------------------|---|--------------------------------------|
| <input type="checkbox"/> Seizures     | <input type="checkbox"/> Areas of Numbness    | <input type="checkbox"/> Concussion  |
| <input type="checkbox"/> Twitches     | <input type="checkbox"/> Lack of Coordination | <input type="checkbox"/> Depression  |
| <input type="checkbox"/> Bad Temper   | <input type="checkbox"/> Loss of Balance      | <input type="checkbox"/> Stress      |
| <input type="checkbox"/> Poor Memory  | <input type="checkbox"/> Anxiety              | <input type="checkbox"/> Mood Swings |
| <input type="checkbox"/> Irritability | <input type="checkbox"/> Tremors              | <input type="checkbox"/> Dizziness   |

## Gynecology

Age of First Menses: \_\_\_\_\_

Duration of Menses: \_\_\_\_\_

Date of Last Menses: \_\_\_\_\_

# of Pregnancies: \_\_\_\_\_

# of Births: \_\_\_\_\_

- Irregular Periods
- Painful Periods
- Breast Lumps
- Spotting
- Vaginal Discharge

- Clots
- PMS
- Menopausal
- Yeast Infections
- Fertility Problems

## Musculo-Skeletal

- Arthritis
- Muscle Weakness
- Muscle Cramping
- Muscle Spasms
- Scoliosis
- Weak Joints

Please Circle Any Areas of Pain:

