

# Patient Intake Form

Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All answers are confidential. Please print clearly in ink.

## IDENTIFICATION

Practitioner \_\_\_\_\_

Name \_\_\_\_\_ Sex  M  F Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_

Single  Married  Partnered  Widowed  Separated/Divorced

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Education \_\_\_\_\_

Emergency contact \_\_\_\_\_ Relation \_\_\_\_\_

Emergency contact telephone: Home \_\_\_\_\_ Cell \_\_\_\_\_

Name of physician\* \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of counselor/psychologist\* \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Name of gynecologist\* \_\_\_\_\_ Phone number \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

\* No contact will be made without your permission.

Your signature \_\_\_\_\_

Special problems or symptoms \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

**FAMILY HISTORY** Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	self (date)	mother	father	sibling	spouse/partner	children
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or other drug use						
Depression or mental illness						
Hepatitis/other liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)	N/A					

**PERSONAL LIFESTYLE HABITS** For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (packs per day) \_\_\_\_\_ Coffee/Tea (cups per day) \_\_\_\_\_  
 Alcohol (drinks per week) \_\_\_\_\_ Soda (regular or diet) \_\_\_\_\_  
 Drug use (recreational) \_\_\_\_\_ Exercise  Yes  No How often? \_\_\_\_\_  
 What kind of exercise? \_\_\_\_\_

**MEDICAL** If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list all of them below: (do not include normal pregnancies).

YEAR	OPERATION/ ILLNESS	HOSPITAL OR TREATMENT LOCATION

**MEDICINES** Please list all medications, vitamins and/or food supplements you are currently taking:

Medications \_\_\_\_\_ Dosage \_\_\_\_\_ For what condition? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Vitamins \_\_\_\_\_ Dosage \_\_\_\_\_ For what condition? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 Food Supplements \_\_\_\_\_ For what condition? \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## CURRENT AND PAST CONDITIONS/SYMPTOMS/TRAUMAS

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experienced the condition both in the past and currently.

### General

- Insomnia
- Dreams/ nightmares
- Fatigue
- Poor memory
- Strongly like cold drinks
- Strongly like hot drinks
- Recent weight loss/gain
- Cold hands & feet
- Chills
- Fever
- Bad breath
- Other (describe)  
\_\_\_\_\_

### Head & Neck

- Headaches
- Migraines
- Stiff neck
- Dizziness
- Fainting
- Swollen glands
- Other (describe)  
\_\_\_\_\_

### Ears

- Ringing
- Hearing loss
- Hearing aids
- Infections
- Earache
- Vertigo
- Other (describe)  
\_\_\_\_\_

### Eyes

- Glasses/ contact lenses
- Blurred vision
- Poor night vision
- Spots or floaters
- Eye inflammation
- Double vision
- Glaucoma
- Cataracts
- "Lazy" eye
- Other (describe)  
\_\_\_\_\_

### Nose, Throat & Mouth

- Sinus infection
- Hay fever/ allergies
- Frequent sore throat
- Difficulty swallowing
- Mouth & tongue ulcers
- Frequent colds
- Nosebleed
- Dry nose
- Nasal congestion
- Loss of voice
- Thirst
- Excessive phlegm
- TMJ
- Facial pain
- Gum problems
- Dry mouth
- Other (describe)  
\_\_\_\_\_

### Skin

- Hives
- Rashes
- Eczema/ psoriasis
- Night sweating
- Excess sweating
- Dry skin
- Easily bruised
- Changes in moles, lumps
- Itching
- Other (describe)  
\_\_\_\_\_

### Respiratory

- Difficulty breathing
- Difficulty breathing when reclining
- Wheezing
- Asthma
- Chronic cough
- Wet cough
- Dry cough
- Coughing up phlegm
- Coughing up blood
- Shortness of breath
- Tight chest
- Pneumonia
- Other (describe)  
\_\_\_\_\_

### Cardiovascular

- High blood pressure
- Low blood pressure
- Chest pain or tightness
- Palpitation
- Rapid heart beat
- Irregular heart beat
- Poor circulation
- Swollen ankles
- Phlebitis
- Anemia
- History of heart disease
- Heart murmur
- Other (describe)  
\_\_\_\_\_

### Gastrointestinal

- Nausea
- Indigestion
- Stomach pain
- Diarrhea
- Constipation
- Poor appetite
- Excessive hunger
- Vomiting
- Gas
- Hiccups
- Acid regurgitation
- Bloating
- Laxative use
- Bloody stool
- Other (describe)  
\_\_\_\_\_

### Musculoskeletal

- Joint pain/swelling
- Sore muscles
- Weak muscles
- Difficulty walking
- Pain (describe)  
\_\_\_\_\_  
\_\_\_\_\_
- Limited range of motion
- Other (describe)  
\_\_\_\_\_

**Neurological**

- Seizures
- Tremors
- Numbness or tingling
- Pain (describe)
- Paralysis
- Poor coordination
- Other (describe)

**Mental/Emotional**

- Depression
- Mood swings
- Irritability
- Difficulty relaxing
- Loneliness
- Sensitive
- Shyness
- Frequent crying
- Worries frequently
- Compulsive behaviors
- Difficulty focusing
- Hopeless outlook
- Suicidal thoughts
- Lose temper
- Frustration
- Other (describe)

**Urinary**

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Incontinence
- Incomplete urination
- Bedwetting
- Wake to urinate
- Kidney (specify)
- Other (describe)

**Male Genital**

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles
- Increased libido
- Decreased libido
- Other (describe)

**Gynecology (Women Only)**

- Currently pregnant
- # of Pregnancies
- # of Live births
- # of Miscarriages
- # of Abortions
- Menopause
- Irregular periods
- Menstrual cramps
- Excessive blood flow
- Menstrual blood clots
- Breast tenderness
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/itching
- Uterine fibroids
- Endometriosis
- Breast lumps, cysts
- Increased libido
- Decreased libido
- Other (describe)

**Infection Screening (circle self and/or partner)**

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted disease: self or partner (specify)
- Other (describe)

**Trauma (list)**

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**Other Information**

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Patient Signature

Date