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INFORMATION FORM

(Please Print)

Today's Date:						E-MAIL:		
PATIENT INFORMATION								
Patient's last name:	First:	Middle:	☐ Mr. ☐ Mrs.	☐ Miss ☐ Ms.	Marital status: Single ☐ Mar ☐ Div ☐ Sep ☐ Wid ☐			
Do you work full time? ☐ Yes ☐ No	Occupation?	Work Phone No.: ( ) / SSN:			Birth date:	Age:	Sex: ☐ M ☐ F	
Street address:			Home Phone No.: ( )			Cell Phone No.: ( )		
P.O. box:	City:			State:		ZIP Code:		
Referred by (Please check one box):			☐ Dr.			☐ Internet	☐ Hospital	
☐ Family	☐ Friend	☐ Close to home/work	☐ Magazine / Newspaper	☐ Other				
Other family members seen here:								

CONTACT NUMBERS	
Spouse/Partner/Parent name:	Phone no.: ( )

CURRENT HEALTH CARE TEAM		
Your Primary Care Doctor:	Phone no.: ( )	
Specialty Doctor :	Type of care:	Phone no.: ( )
Specialty Doctor:	Type of care:	Phone no.: ( )
Specialty Doctor:	Type of care:	Phone no.: ( )

DATE:

Please remember to frequently click "save"

Name *(Last, First, M.I.)*:

Patient intake form

WHAT ARE YOUR GOALS FOR THIS VISIT?

WHAT PRIOR EXPERIENCES HAVE YOU HAD WITH ALTERNATIVE OR COMPLEMENTARY MEDICINE?

PRIORITIZE YOUR MOST IMPORTANT HEALTH CONCERNS TODAY:

CONCERN	ONSET (DATE)	FREQUENCY	SEVERITY (MILD/MOD/SEVERE)

WHAT ARE THE MAJOR STRESSORS IN YOUR LIFE?

WHAT DO YOU DO TO RELIEVE STRESS? WHAT INTERESTS/HOBBIES DO YOU HAVE?

WHAT PHYSICAL ACTIVITY DO YOU PARTICIPATE IN AND HOW OFTEN?

ENERGY LEVEL:

DESCRIBE YOUR SLEEP PATTERN:

Please remember to frequently click “save”

Name *(Last, First, M.I.):*

Patient intake form (page 2)

Exercise	☐ Sedentary (No exercise)		
	☐ Mild exercise (i.e., climb stairs, walk 3 blocks, golf)		
	☐ Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)		
	☐ Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)		
Diet	ARE YOU CURRENTLY ON A SPECIAL DIET (FOODS AVOID, VEGETARIAN, ETC) – PLEASE EXPLAIN………	☐ Yes	☐ No
	# of meals you eat in an average day?		

TYPICAL BREAKFAST	TYPICAL LUNCH	TYPICAL DINNER	TYPICAL SNACKS

# of servings of fruit you eat in an average day?
# of servings of vegetables do you eat in an average day?

HOW WOULD YOU DESCRIBE YOUR RELATIONSHIP WITH FOOD? :

Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	# of cups/cans per day?				
	What Non-Caffeine Beverages do you drink on a Typical Day and How Much?				
Alcohol	Do you drink alcohol?			☐ Yes	☐ No
	If yes, what kind?				
	How many drinks per week?				

MENTAL HEALTH

Is stress a major problem for you?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Do you panic when stressed?	☐ Yes	☐ No
Do you have problems with eating or your appetite?	☐ Yes	☐ No
Do you cry frequently?	☐ Yes	☐ No
Do you have trouble sleeping?	☐ Yes	☐ No

HAVE YOU SEEN A PSYCHOTHERAPIST IN THE PAST? IF SO, PLEASE EXPLAIN:

Please remember to frequently click "save"

Name *(Last, First, M.I.)*:

Patient intake form (page 3)

CHILDHOOD ILLNESS:	☐ Measles ☐ Mumps ☐ Rubella ☐ Chickenpox ☐ Rheumatic Fever ☐ Polio	
Immunizations	☐ Tetanus	☐ Pneumonia
	☐ Hepatitis	☐ Chickenpox
	☐ Influenza	☐ MMR Measles, Mumps, Rubella

LIST ANY MEDICAL PROBLEMS THAT OTHER DOCTORS HAVE DIAGNOSED

SURGERIES

Year	Reason	Hospital

OTHER HOSPITALIZATIONS

Year	Reason	Hospital

HAVE YOU EVER HAD A BLOOD TRANSFUSION? ☐ Yes ☐ No

LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS

Name the Drug or Vitamin	Strength	Frequency Taken

Continued on next page

Please remember to frequently click “save”

Name *(Last, First, M.I.):*

Patient intake form (page 4)

CONTINUED….LIST YOUR PRESCRIBED DRUGS AND OVER-THE-COUNTER DRUGS, SUCH AS VITAMINS AND INHALERS		
Name the Drug or Vitamin	Strength	Frequency Taken

ALLERGIES TO MEDICATIONS	
Name the Drug	Reaction You Had

Personal Medical History

Please check the following conditions that apply to you. If a choice is given, please circle the appropriate one.

☐ Alcoholism or Substance Abuse	☐ Digestive (UC. Crohns, IBS, etc)	☐ Heart Attack/Disease Failure
☐ Anemia	☐ Easy Bleeding	☐ Heart Murmur
☐ Arthritis/Joint Disease	☐ Frequent Sinusitis	☐ Headaches (Migraines)
☐ Blood Clots/Phlebitis	☐ Gall Bladder	☐ High Blood Pressure
☐ Cancer*	☐ Hay Fever, Allergy, Eczema	☐ High Cholesterol
☐ Diabetes	☐ Hearing Loss	

☐ History of Infertility	☐ Lung Disease (Asthma, COPD)	☐ Seizures, Epilepsy
☐ Radiation Treatments	☐ Pneumonia	☐ Skin Disease
☐ Serious Injury or Accident*	☐ Sexually Transmitted Disease*	☐ Tuberculosis
☐ Stroke	☐ Thyroid Disease	☐ Other
☐ Urinary Difficulties (Incontinence, UTI, etc	☐ Vision/Eye Problems	
☐ Kidney Infection/Stones	☐ Liver Disease, Hepatitis, etc	

NOTES FROM ABOVE CONDITIONS: (* TYPES OF CANCER/SERIOUS ACCIDENTS OR INJURY/SEXUALLY TRANSMITTED DISEASE

Please remember to frequently click "save"

Name *(Last, First, M.I.):*

Patient intake form (page 5)

WOMEN ONLY

Age at onset of menstruation:		
Date of last menstruation:		
Period every days		
Heavy periods, irregularity, spotting, pain, or discharge?	☐ Yes	☐ No
Number of pregnancies Number of live births		
Are you pregnant or breastfeeding?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Date of last pap and rectal exam?		
Other Problems:		

MEN ONLY

Do you have Prostate Problems?	☐ Yes	☐ No
Sexual Dysfunction	☐ Yes	☐ No
Testicular Cancer	☐ Yes	☐ No
Vasectomy	☐ Yes	☐ No
Other Problems:		

Please remember to frequently click "save"

Name *(Last, First, M.I.):*

Patient intake form (page 6)

Review of Systems

Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain.

☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears ☐ Eyes	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
FATHER			***Children***	☐M ☐ F	
MOTHER				☐M ☐ F	
Sibling	☐M ☐ F			☐M ☐ F	
	☐M ☐ F			☐M ☐ F	
	☐M ☐ F		**GRANDMOTHER** Maternal		
	☐M ☐ F		**GRANDFATHER** Maternal		
	☐M ☐ F		**GRANDMOTHER** Paternal		
	☐M ☐ F		**GRANDFATHER** Paternal		

PLEASE FEEL FREE TO USE THE REMAINING SPACE TO DISCUSS ANYTHING ELSE YOU WISH ME TO KNOW ABOUT YOUR LIFE, HEALTH, EMOTIONS, THE KIND OF PERSON YOU ARE, GOALS, CONCERNS, ETC. THANK YOU FOR TAKING THE TIME TO COMPLETE THIS FORM.

Signature

Date