Patient intake

Date_______________________

Full Legal Name____

Date of Birth_______________ Age_____________ ☐ Male ☐ Female

I was referred by: ☐ A Friend: who? ___________________ ☐ Internet Search ☐ Article ☐ Social Media (i.e Facebook)

☐ Print AD: where?____

Health Concerns

Top 3 Health Concerns	When did it begin?	Has it been diagnosed?	Are you receiving treatment for the condition?
1.			
2.			
3.			

What else would you like to accomplish on your first visit?

____

____

____

____

Healthcare Providers Information

Primary Care Physician ____

Phone Number ____

When was your last physical exam? ____

Are you currently seeing a specialist outside of your primary care physician? ☐ Yes ☐ No

1. Physician's Name ____

   Practice____

   Phone Number ____

2. Physician's Name ____

   Practice ____

   Phone Number ____

Please list all major surgeries or Hospitalizations

Procedure	Year

Known Drug allergies or Reactions

Please list **ALL** known allergies (medications, supplements, food, environmental, vaccinations).

Allergy	Type of Reaction

Do you have an issue with local anesthetics such as epinephrine? ☐ Yes ☐ No

(Like what the Dentist would use?)

Explain:____

Have you ever had a racing heart from a local anesthetic? ☐ Yes ☐ No

Please list any **medications** and **supplements** you are currently taking, along with doses and the reason you are taking them.

Medications	Reason	Date Began	Dose	Effective? (Yes/No)

Supplements	Reason	Date Began	Dose	Effective? (Yes/No)

Hormones

Are you currently taking any Hormone Replacement Therapy? ☐ Yes ☐ No
If yes, please list them:

Hormone Prescription	Date Started

Lifestyle

Relationship: ☐ Single ☐ Married/Partnership ☐ Separated

☐ Divorced ☐ Widowed

If married/partnership, how long have you been together? ______________________

Name of Partner______________________

Are you sexually active? ☐ Yes ☐ No

If yes, with (check one)? ☐ Male ☐ Female ☐ Both

Do you or your partner(s) use contraception? ☐ Yes ☐ No

If yes, what type(s)? ______________________________

Are you pregnant? ☐ Yes ☐ No

Trying to get pregnant? ☐ Yes ☐ No

If yes, for how long? ______________________________

Do you have children? ☐ Yes ☐ No How many?______________________________

Names and ages of your children?

____

____

Have you ever been a victim of abuse (physical, verbal, emotional)? ☐ Yes ☐ No

To what extent are you open to changes in your lifestyle to address your health concerns?

☐ I will do whatever it takes

☐ I am willing to make some changes

☐ I am willing to consider changes

Social History

Are you currently a smoker? ☐ Yes ☐ No

If yes, how long have you been smoking?

____

Have you ever been a smoker? ☐ Yes ☐ No

For how long? ______________________________

How often do you drink alcohol? (Please list amount & type)

____

____

Do you use recreational drugs? ☐ Yes ☐ No

How often do you exercise? ____________________

What kind of exercise do you do? ____________________

How long do you exercise at a time? ____________________

What do you do to relax? ____________________

Describe your supportive network: ____________________

Do you have a spiritual practice? ____________________

What is your occupation? ____________________

Do you like your job? ☐ Yes ☐ No

How many hours a week do you work? ____________________

How many hours a night do you sleep? ____________________

Do you have trouble falling/staying asleep? ☐ Yes ☐ No

Falling/Staying/Both? ____________

Do you wake refreshed? ☐ Yes ☐ No

Diet

Please describe a typical day's diet for you.

Breakfast	**Lunch**	**Dinner**	**Snacks (what hour)**

How many meals do you eat daily? ____________________

How much water do you drink daily? ____________________

How many sodas, coffees, and teas with caffeine do you drink per week? ________

Do you have dietary restrictions? ☐ Yes ☐ No

Describe:____________________

Are you satisfied with your current diet? ☐ Yes ☐ No

Environmental Exposure

Do you think you are chemically sensitive? Explain.

____

____

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, work or even when traveling? ☐ Yes ☐ No

Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide? ☐ Yes ☐ No

Are you sensitive to perfume, gasoline or other vapors? ☐ Yes ☐ No

Have you ever lived near a refinery or polluted area? ☐ Yes ☐ No

Have you ever lived in a home more than 50 years old? ☐ Yes ☐ No

Do you have mercury dental fillings? How many?_______ ☐ Yes ☐ No

Have you had any dental root canal procedures? ☐ Yes ☐ No

Do you live near power lines? ☐ Yes ☐ No

Review of Systems: Y- Presently have N- Never had P- Have had in the past

General

Energy (on scale of 0-10)	
Weight Gain	☐Y ☐N ☐P

Skin

Acne	☐Y ☐N ☐P
Bruise Easily	☐Y ☐N ☐P
Eczema	☐Y ☐N ☐P
Itching	☐Y ☐N ☐P
Lumps	☐Y ☐N ☐P

Gastrointestinal

How often do you have a bowel movement? ____________________________________

Belching/Gas	☐Y ☐N ☐P
Bloating	☐Y ☐N ☐P
Constipation	☐Y ☐N ☐P
Diarrhea	☐Y ☐N ☐P
Heartburn	☐Y ☐N ☐P
Nausea	☐Y ☐N ☐P
Trouble Swallowing	☐Y ☐N ☐P
Ulcer	☐Y ☐N ☐P
Undigested Food in Stool	☐Y ☐N ☐P

Head/Eyes/Ears/Nose/Throat

Headaches/Migraines	☐Y ☐N ☐P
Cataracts	☐Y ☐N ☐P
Dryness	☐Y ☐N ☐P
Eye Pain	☐Y ☐N ☐P
Glasses/Contacts	☐Y ☐N ☐P
Glaucoma	☐Y ☐N ☐P
Tearing	☐Y ☐N ☐P
Vision Problems	☐Y ☐N ☐P
Ear Pain	☐Y ☐N ☐P
Impaired Hearing	☐Y ☐N ☐P
Ringing	☐Y ☐N ☐P
Nosebleeds	☐Y ☐N ☐P
Post Nasal Drip	☐Y ☐N ☐P

Sinus Problems	☐ Y ☐ N ☐ P
Frequent Sore Throat	☐ Y ☐ N ☐ P
Goiter	☐ Y ☐ N ☐ P
Gum Problems	☐ Y ☐ N ☐ P
Hoarseness	☐ Y ☐ N ☐ P
Jaw Clicking/Pain	☐ Y ☐ N ☐ P
Lumps/Swollen Glands	☐ Y ☐ N ☐ P
Neck Pain/Stiffness	☐ Y ☐ N ☐ P
Sore Tongue	☐ Y ☐ N ☐ P

Neurologic

Loss of Balance	☐ Y ☐ N ☐ P
Loss of Memory	☐ Y ☐ N ☐ P
Muscle Weakness	☐ Y ☐ N ☐ P
Numbness	☐ Y ☐ N ☐ P
Paralysis	☐ Y ☐ N ☐ P
Tingling	☐ Y ☐ N ☐ P

Respiratory

Asthma	☐ Y ☐ N ☐ P
Cough	☐ Y ☐ N ☐ P
Difficult Breathing	☐ Y ☐ N ☐ P
Emphysema	☐ Y ☐ N ☐ P
Positive TB Test	☐ Y ☐ N ☐ P

Cardiovascular

Anemia	☐ Y ☐ N ☐ P
Chest Pain	☐ Y ☐ N ☐ P
Cold Hands/Feet	☐ Y ☐ N ☐ P
Heart Disease	☐ Y ☐ N ☐ P
Hemorrhoids	☐ Y ☐ N ☐ P
High Blood Pressure	☐ Y ☐ N ☐ P
Low Blood Pressure	☐ Y ☐ N ☐ P
Leg Cramps	☐ Y ☐ N ☐ P
Murmur	☐ Y ☐ N ☐ P
Palpitations	☐ Y ☐ N ☐ P
Poor Circulation	☐ Y ☐ N ☐ P

Swelling of Feet	☐Y ☐N ☐P
Varicose Veins	☐Y ☐N ☐P

Endocrine

Generally Feel Cold	☐Y ☐N ☐P
Generally Feel Hot	☐Y ☐N ☐P
Low Blood Sugar/Diabetes	☐Y ☐N ☐P
Recently Lost Weight	☐Y ☐N ☐P
Sluggish After Eating	☐Y ☐N ☐P

Male Only

Testicular Mass	☐Y ☐N ☐P
STD	☐Y ☐N ☐P
Testicular Pain	☐Y ☐N ☐P
Erectile Dysfunction	☐Y ☐N ☐P
Trouble with Urination (Frequently, Hesitancy, Pain, Dribbling)	☐Y ☐N ☐P
Prostate Conditions	☐Y ☐N ☐P
Date of Last Prostate Exam	
Libido (On a Scale of 0-10)	

Female Only

Discharge/Itching	☐Y ☐N ☐P
Vaginal Dryness	☐Y ☐N ☐P
STD	☐Y ☐N ☐P
Irregular Mass	☐Y ☐N ☐P
Pain During Intercourse	☐Y ☐N ☐P
Fibrocystic Breasts	☐Y ☐N ☐P
Cancer: Breast/Cervical/Ovarian	☐Y ☐N ☐P
Libido (On a Scale of 0-10)	☐Y ☐N ☐P

Date of last Pap Smear: ______________________________ Abnormal Pap? __________________________

Date of last Period: ____________________ Bleeding: ☐ Heavy ☐ Moderate ☐ Light

Onset of first menses age:_______________________

Periods Generally last ______________ days and occur every _______________days.

Do you preform monthly breast exams? ☐ Yes ☐ No

When was your last breast exam? ______________________________

Do you have regular mammograms? ☐ Yes ☐ No

Are you Currently on oral contraceptives (i.e the birth control pill)? ☐ Yes ☐ No

What is it exactly?____

Have you had your uterus removed (i.e **hysterectomy**)? ☐ Yes ☐ No

If yes, when? ____

Have you had a **Uterine Ablation Procedure**, where your uterine lining was removed?
(This is **NOT** a D and C procedure) ☐ Yes ☐ No

If yes, when?____

Family History

Relative	Age (If Living)	Age/Cause of Death	Ailments
Mother			
Father			
Sibling			
Grandmother			
Grandmother			
Grandfather			
Grandfather			

____

Signature

____

Date