

***new patient intake form***

Name: DOB/AGE:

Street Address:

City, State, Zip:

Phone--Home: Mobile:

Email:

Please indicate how you would like to be contacted: Home phone Mobile Text Email

Emergency contact name and number:

Your occupation:

Marital status:

Living situation:

Whom may I thank for referring you?

Please list the names & phone numbers of any Drs. Or Practitioners you would like me to consult with:

Please list ALL prescription and non-prescription drugs (i.e. over the counter, vitamins, supplements, herbs, etc.) currently being taken. Include any taken occasionally, such as aspirin for headaches, as well as those taken daily. (Use back of page if needed.)

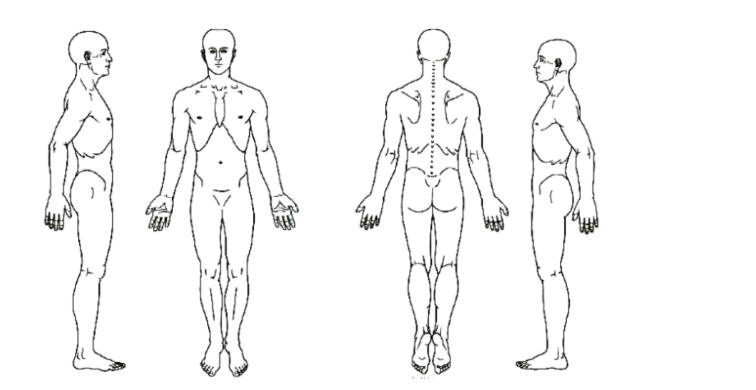
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| --- | --- | --- |
| Name | Dose and how often | Reason for Taking |
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What is the primary concern you would like to address in treatment?

Other issues or concerns?

**Musculoskeletal:**

Using an X, please indicate any areas of current pain or weakness of the diagram below:



Please describe each:

Please list any past accidents, injuries or surgeries, including dates:

Do you experience numbness and/or tingling in any part of your body? Yes No

If yes, please explain:

**Exercise:**

Type and frequency of exercise / movement:

**Sleep:**

What time do you go to sleep?

What time do you wake?

Do you feel rested when you wake? Yes No

Difficulty: Falling asleep Staying asleep Toss & turn Waking early, unable to get back to sleep

Dreams: Vivid dreams Nightmares I don’t dream

Other sleep issues:

**Temperature:**

Do you tend to feel hot or cold and/or experience hot flashes or cold chills? Yes No

If yes, please explain:

Do your feet and/or hands tend towards cold? Yes No

If yes, please explain:

**Stress & Anxiety:**

What is your level of stress and/or anxiety on a scale of 1 -10 (10 being the most stressed / anxious):

What triggers your stress / anxiety?

Do you have panic attacks? Yes No

If yes, please describe:

What helps you conquer stress / anxiety?

**Energy level:**

(Use a scale of 1 -10, 10 being having enough energy to get through your day easily with some left over)

Overall:

Upon waking:

Time of day of peaks and low ebbs:

**Headaches:**

Do you get headaches? Yes No

If yes, how often? Occasionally Weekly Daily

Where does it occur in or on your head, and what does it feel like? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you experience dizzy spells? Yes No

If yes, how often? Occasionally Weekly Daily

**Memory:**

Do you have any issues with your memory? Yes No

If yes, please explain:

“Foggy” brain or “fuzzy” thinking? Yes No

If yes, please explain:

**Eyes:** Issues with Vision Floaters Dryness Redness Itchy Other:

**Nose:**  Congestion Runny Decreased sense of smell Other:

**Ears:** Ringing Loss of Hearing Sound Sensitivity Rushing Noise Other:

**Allergies:**

Do you have allergies to foods, products, and/or environment: Yes No

If yes, please explain:

Is it seasonal: Yes No

**Teeth/Jaw:**  TMJ Teeth Grinding Jaw Pain Other:

**Chest & Breathing:**

Tightness Pain Palpitations Asthma Shortness of Breath Other:

How often? Occasionally Weekly Daily Other:

Cough: Morning Daytime Nighttime All the time

Is it: Dry Phlegm Producing Difficult to expectorate Phlegm

What color, if any, is the phlegm? Clear White Yellow Brown Green

Do you use tobacco (currently or in the past)? Yes No

If yes, for how long and how often per day / week?

**Appetite:**

Do you get hungry during the day? Yes No

Do you feel like you eat too much or too little? Too much Too little No

Do you feel energized after eating or feel like you need a nap? Energized Nap

Do you crave anything:

**Diet:** What does your food intake on a typical day look like? Please include times of meals.

Breakfast:

Lunch:

Dinner:

Snacks:

**Digestion:**

Do you experience: Bloating Pain after eating BM after eating Frequent gas Heartburn Reflux

Other:

**Abdominal Pain:**

Location of pain (if any): Middle Abdomen Lower Abdomen Both

Related to food intake? Yes No Sometimes

What does the pain feel like? Dull Sharp Like a Spasm

What makes it feel better? Pressure Heat Cold Other:

**Fluid Intake:**

Do you get thirsty? Yes No

How much water do you drink in a day?

How much coffee do you drink in a day?

What kinds of soda do you drink and how often?

What other kinds of beverages (including alcohol) do you drink and how often?

Do you consume “diet” drinks with sugar substitutes? Yes No

If yes, what kind?

What temperature do you prefer your drinks to be? Cold Room Temp Warm Hot

**Bowels:**

How many times a day/week do you have a BM?

Any difficulty in going? Yes No If yes, please describe:

Any pain? Yes No If yes: Before During After

Any blood or mucus in your stool? Yes No

Stool description(s): Well formed Soft Tend toward diarrhea Tend toward constipation

Is the stool ever extra smelly? Yes No Any current or past hemorrhoids? Yes No

**Urination:**

Do you feel your output is about equal to your intake? Yes No

Any dribbling? Yes No Any incontinence? Yes No

Any blood in your urine? Yes No Does it ever burn? Yes No

Color of urine? Clear Light yellow Yellow Dark Yellow

**Menstruation:**

Age of onset: Age of menopause:

Number of days in cycle:

Duration of period:

Color of menses:

Any clots? Yes No If yes, what size? Pea Dime Quarter Other:

Pain (before or during period): Yes No Sometimes Pain level 1 – 10 (10 being worst):

What makes it feel better? Pressure Heat Cold Other:

Breast tenderness: Yes No Sometimes

Mood changes: Yes No Sometimes

Hot flashes: Yes No Sometimes

Any other PMS symptoms:

**Pregnancy History:**

Are you currently pregnant? Yes No If yes, how many weeks? Due Date:

Number of previous pregnancies: Number of births:

Health during pregnancy:

Complications during labor and delivery:

Health postpartum:

Are you currently breastfeeding? Yes No

**Prostate:**

Have you had a prostate exam? Yes No

If yes, when?

Any concerns? Yes No

If yes, please explain:

**Please Briefly describe your vision of yourself in perfect health:**

*I hereby certify that the information above is complete and to the best of my knowledge.*

Patient Printed Name: Date:

Patient Signature (Signature of parent or guardian if under 18):