Date: ____ / ____ / _______

PATIENT INTAKE FORM

Last Name: __________________________ First Name: ______________________ Middle Initial: _____

Address: ____
City State Zip Code

Primary Phone: (______) _______ - _________ Email: ____

Date of Birth: ____ / ____ / ________ Gender: M / F Height: _____'_____" Weight:______ lb

What are your primary health concerns or reasons for scheduling this visit?

____
____
____

Please list other practitioners seen for these conditions/goals, treatments you have attempted, self-care activities you find helpful, and results you have seen:

____
____
____

PERSONAL HEALTH HISTORY

Please check any of the following conditions you have been diagnosed with:

Neurological:
- ☐ Depression
- ☐ Anxiety
- ☐ Bipolar Disorder
- ☐ ADD / ADHD
- ☐ Multiple Sclerosis
- ☐ Parkinson's
- ☐ Seizures
- ☐ Anorexia Nervosa
- ☐ Bulemia
- ☐ Other Eating Disorder

Gastrointestinal:
- ☐ Irritable Bowel Syndrome
- ☐ Irritable Bowel Disease
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis
- ☐ Celiac Disease
- ☐ Gastric or Peptic Ulcer
- ☐ GERD / Reflux
- ☐ Hepatitis C
- ☐ Food Allergy
- ☐ Gall Stones

Cardiovascular:
- ☐ Heart Attack
- ☐ Stroke
- ☐ Hypercholesterolemia
- ☐ Hypertension
- ☐ Arrhythmia

Respiratory:
- ☐ Asthma
- ☐ Chronic Sinusitis
- ☐ Chronic Bronchitis
- ☐ Emphysema
- ☐ Tuberculosis

Metabolic / Endocrine:
- ☐ Type 1 Diabetes
- ☐ Type 2 Diabetes
- ☐ Metabolic Syndrome
- ☐ Hypoglycemia
- ☐ Hypothyroidism
- ☐ Hyperthyroidism
- ☐ PCOS
- ☐ Infertility

Musculoskeletal:
- ☐ Osteoarthritis
- ☐ Migraines
- ☐ Fibromyalgia

Inflammatory:
- ☐ Chronic Fatigue Syndrome
- ☐ Frequent Infections
- ☐ Severe Infectious Disease
- ☐ Rheumatoid Arthritis
- ☐ Lupus / SLE
- ☐ Gout

Urinary / Reproductive:
- ☐ Kidney Stones
- ☐ UTI
- ☐ Yeast Infection
- ☐ Venereal Disease

Dermatological:
- ☐ Eczema
- ☐ Psoriasis
- ☐ Acne

Have you ever been diagnosed with cancer? Y / N If so, what kind? ______________________________

Do you have any other health conditions not listed? ____

Please list any previous injuries, surgeries, and hospitalizations. Include the date or the age at which they occurred.

Injury / Illness / Procedure	Year	Additional Comments

Do you have any artificial joints or implants? Y / N Please explain: ______________________________

Please list any allergies to food, medication, supplements, or environmental chemicals.

____

____

____

____

Medications: Please list all prescription medications, nutritional supplements, and herbs/botanicals you are currently taking.

Medication / Supplement	Dose / Frequency	Year Started	Reason

Have you had prolonged or regular use of NSAIDs, motrin, or aspirin? Y / N

Have you had prolonged or regular use of tylenol? Y / N

Have you had prolonged or regular use of acid-blocking drugs? Y / N

Have you taken antibiotics >3 times per year? Y / N

Have you taken antibiotics long term (>1 month continuously)? Y / N

Have any of your close relatives (grandparent, parent, sibling, or child) been diagnosed with the following conditions? Please check and note the family member with the condition.

Condition	Present	Note which Family Member
Heart Disease	☐	
High Blood Pressure	☐	
Stroke	☐	
Diabetes	☐	
Cancer	☐	
Overweight	☐	
Autoimmune Disease	☐	
Food Sensitivity	☐	

SYMPTOMS SURVEY

Score every symptom based on the last 30 days using the following scale.

- 0: Do not suffer from this ever or almost ever
- 1: Suffer <2 per week and is mild to moderate
- 2: Suffer 2+ per week and is mild to moderate
- 3: Suffer <2 per week and is severe
- 4: Suffer 2+ per week and is severe

Constitutional:
- ☐ Fatigue / Sluggishness
- ☐ Hyperactive / Nervous Energy
- ☐ Restless / Can't Relax
- ☐ Sleepiness During the Day
- ☐ Insomnia at Night
- ☐ Malaise
- ☐ Fever / Chills

Neurologic:
- ☐ Fainting / Blackouts
- ☐ Numbness
- ☐ Paralysis
- ☐ Dizziness
- ☐ Tremors
- ☐ Seizures

Emotional / Mental:
- ☐ Depression
- ☐ Anxiety / Nervousness
- ☐ Mood Swings
- ☐ Irritability
- ☐ Forgetfulness
- ☐ Lack of Concentration / Focus

Cardiovascular:
- ☐ Irregular Heartbeat
- ☐ Palpitations
- ☐ High Blood Pressure
- ☐ Chest Pain
- ☐ Shortness of Breath
- ☐ Swollen Feet or Lower Legs
- ☐ Leg Cramps
- ☐ Blood Clots
- ☐ Anemia
- ☐ Bruise Easily

Endocrine:
- ☐ Excessive Thirst or Hunger
- ☐ Excessive Sweating
- ☐ Lack of Sweating
- ☐ Heat or Cold Intolerance
- ☐ Hair Loss
- ☐ Dizzy when Standing Quickly
- ☐ Excessive weight loss
- ☐ Excessive weight gain

Respiratory Tract:
- ☐ Sinus Pains
- ☐ Runny Nose
- ☐ Nasal Congestion
- ☐ Frequent Sneezing
- ☐ Wheezing
- ☐ Chest congestion
- ☐ Coughing
- ☐ Trouble Breathing with Exercise

Digestive:
- ☐ Poor Appetite
- ☐ Nausea / Vomiting
- ☐ Belching
- ☐ Heartburn / Reflux
- ☐ Trouble Swallowing
- ☐ Stomach Pains / Cramping
- ☐ Bloating
- ☐ Gas
- ☐ Change in Stool
- ☐ Constipation
- ☐ Diarrhea
- ☐ Painful Elimination
- ☐ Blood in Stool
- ☐ Incontinence

Genitourinary:
- ☐ Increased Urinary Frequency
- ☐ Urinating > 1 time per night
- ☐ Painful Urination
- ☐ Blood in Urine

Musculoskeletal:
- ☐ Joint Pains or Achiness
- ☐ Stiff Joints
- ☐ Muscle Pains or Achiness
- ☐ Pain Relief with NSAIDS

Head / Ears:
- ☐ Headaches
- ☐ Migraines
- ☐ Earache
- ☐ Ear Infection
- ☐ Ringing in Ears
- ☐ Vertigo / Dizziness

Mouth / Throat
- ☐ Bleeding Gums
- ☐ Swelling of Lips / Tongue
- ☐ Goiter
- ☐ Lumps / Swollen Glands
- ☐ Mouth Sores

Eyes
- ☐ Red / Swollen Eyes
- ☐ Watery Eyes
- ☐ Itchy Eyes
- ☐ Cataracts / Glaucoma
- ☐ Eye Pain
- ☐ Double Vision

Skin:
- ☐ Blemishes / Acne
- ☐ Rashes / Hives
- ☐ Cheek Redness
- ☐ Eczema
- ☐ Dry Skin
- ☐ Itching
- ☐ Change in Skin / Nails

Sexual (Female):
- ☐ Bleeding Between Periods
- ☐ Decreased Sexual Interest
- ☐ Pain with Intercourse
- ☐ Discharge
- ☐ Itching
- ☐ Sores
- ☐ Yeast infections
- ☐ PMS
- ☐ Breast Tenderness

Sexual (Male):
- ☐ Prostate Problems
- ☐ Hernia
- ☐ Erection Trouble
- ☐ Discharge
- ☐ Premature Ejaculation
- ☐ Sexually Transmitted Disease
- ☐ Testicular Lumps / Pain
- ☐ Itching / Rashes
- ☐ Vasectomy

LIFESTYLE AND NUTRITION SURVEY

Do you engage in physical activity on a regular basis? Y / N

If so, list the type and duration of activity:______________________________

How long have you been participating in the above activities? ____________________

How physically active is your daily routine? Not active Light Moderate Heavy

How many hours do you sleep on weekends? ________ hours Weeknights? ________ hours

Do you have problems falling asleep at night? Y / N

Do you have problems with waking up at night? Y / N

Do you have problems waking up not feeling rested? Y / N

ENVIRONMENTAL HISTORY

What is your job? ____

Circle any of the following to which you are regularly exposed:

Cigarette Smoke Paint fumes Perfumes Nail Polish

Auto Exhaust Chemicals Hair dyes Dry-cleaned Clothes

Do you feel dizzy or get a headache when exposed to strong odors? Y / N

Do you feel worse at certain times of the year? Y / N

If yes, when? Spring Summer Fall Winter

SOCIAL HISTORY

With whom do you live? ____

Do you have children? Y / N How many? ________ Please list the ages: ________________

How many pets do you have? _______ Please list the kinds: __________________________

Have you or your family recently experienced any major life changes? Y / N

If yes, please comment: ____

Have you ever had psychotherapy or counseling? Y / N What kind? ____________________

Comments: ____

Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Y / N If not, explain: __________________________________

FEMALE HEALTH HISTORY

For Females Only:

What was your age at your first period? _______ What was your age at menopause (if applicable)? _______

Average cycle length: ________ days Usual length of period: _______ days bleeding

Do / did you experience PMS? Y / N If so, note symptoms: ________________________

Have you been pregnant? Y / N Number of pregnancies: _______ Number of deliveries: _______

Did you have any difficulties with conception? Y / N Did you use fertility drugs? Y / N

Complications with pregnancies: ____________________________________

Do you use any birth control? Y / N Please note type and duration: ____________________

Are you on any HRT? Y / N If so, list type and reason: __________________________

NUTRITION HISTORY

Are you currently following a particular diet or nutrition plan? Y / N

If yes, please explain: ____________________

Do you avoid any particular foods? Please explain. ____________________

____

Do you have any adverse food reactions? Please explain. ____________________

____

Do you have symptoms immediately after eating, such as belching, bloating, sneezing, hives, etc. Y / N

If so, are these symptoms associated with any particular food or supplements? Y / N

Bowel Movement Consistency:

- ☐ Soft and well formed
- ☐ Often float
- ☐ Loose but not watery
- ☐ Difficult to pass
- ☐ Diarrhea
- ☐ Alternating between hard/loose
- ☐ Thin, long or narrow
- ☐ Small and hard

Bowel movement frequency: Irregular 1-3 times per day >3 times per day

Do you ever notice blood in your stool? Y / N If so, approximately how often?____________

Regarding intestinal gas, I notice it being (circle all that apply):

Daily Occasional Excessive Accompanied by pain Excessively foul smelling

Please check if you feel worse after eating a lot of:

☐ high fat foods ☐ high protein foods ☐ high carb foods ☐ refined sugars

☐ fried foods ☐ 1-2 alcoholic beverages

Does skipping a meal greatly affect your symptoms? Y / N

If so, explain: ____________________

How many meals do you eat each day? __________ How many snacks do you eat each day? __________

Are there any foods you crave? ____________________

How many fast food meals do you get from a restaurant or fast food per week? ____________

Do you do the grocery shopping? Y / N Do you do the cooking at home? Y / N

Do you drink alcohol? Y / N If so, how many drinks per week? __________

Do you drink caffeinated beverages? Y / N If so, how many cups per day? __________

Do you use natural or artificial sweeteners? Y / N If so, which ones? ____________

Have you ever used tobacco? Y / N If yes, how many years were you a nicotine user: ____________

Packs per day: _________ If you quit, how long has it been since you quit? ________ years

What is your usual weight range? ____________ What is your desired weight? ____________

Any recent weight loss or gain? Y / N If so, approximately how many pounds?____________

Please bring completed intake form to your appointment.