PATIENT INTAKE FORM

Name_____ **Date**_____

Referred by: _____
Chief Complaint: _____

What are your expectations after treatment in this clinic? _____
_____

Past Medical History (include dates)
Significant Illnesses □ Cancer ____ □ Diabetes ____ □ High Blood Pressure _____ □ Heart Disease _____
□ Hepatitis ____ □ Rheumatic Fever ____ □ Thyroid Disease ____ □ Seizure ____ □ Other _____
Surgeries _____
Significant Trauma (auto accident, falls, emotional, etc.) _____
_____
Birth History (prolonged labor, forceps delivery, etc.) _____
Allergies (drugs, chemicals, foods) _____
Prescription Medications _____
Supplements _____
Occupational Stresses (chemical, physical, psychological, etc.) _____
Exercise _____

Average Daily Diet
Morning Afternoon Evening

Habits Cigarettes # _____ Coffee _____ Tea _____ Soda _____ Alcohol _____ Drugs _____ Sugar _____
Salt ____ Other _____

Family Medical History Diabetes_____ Cancer_____ High Blood Pressure_____ Heart Disease_____
Stroke _____ Seizures _____ Asthma _____ Alcoholism _____ Other _____
Notes _____

Social History Married ____ Divorced _____ Single ____ Children (how many) ____ Ages _____

General

□ Poor Appetite	□ Heavy Appetite	□ Poor Sleep	□ Heavy Sleep	□ Insomnia
□ Fatigue	□ Tremors	□ Vertigo	□ Cold Hands	□ Cold Feet
□ Cold Back	□ Cold Abdomen	□ Night Sweats	□ Sweats Easily	□ Fever
□ Chills	□ Change of Appetite	□ Localized Weakness	□ Poor Coordination	□ Cravings

□ Sudden drop in energy at (time) _____ □ Strong thirst (cold/hot drinks) _____
□ Peculiar Taste/Smells _____ □ Bleed or bruise easily (where) _____

Head, Eyes, Ears, Nose and Throat

□ Dizziness	□ Concussion	□ Migraines	□ Glasses	□ Eye Strain
□ Eye Pain	□ Poor Vision	□ Night Blindness	□ Color Blindness	□ Cataracts
□ Blurry Vision	□ Sinus Problems	□ Poor Hearing	□ Ringing in Ears	□ Earaches
□ Nose Bleeds	□ Dry Throat	□ Dry Mouth	□ Copious Saliva	□ Mucous
□ Jaw Clicks	□ Teeth Problems	□ Grinding Teeth	□ Gum Problems	□ Facial Pain
□ Spots in Eyes	□ Lip Sores	□ Tongue Sores	□ Recurrent Sore Throats ____/Month	

□ Headaches (where/when) _____ □ Other Head or Neck Problems: _____

Dental
□ Amalgams □ Root Canals □ Crowns □ Periodontal Disease □ Tooth Decay □ Braces □ Bridges

Respiratory
□ Cough □ Blood in Sputum □ Asthma □ Bronchitis □ Pneumonia
□ Difficult Breathing While Lying Down □ Production of Phlegm/Color _____
□ Other Lung Problems: _____

Cardiovascular
□ Chest Pain □ High Blood Pressure □ Low Blood Pressure □ Fainting □ Dizziness
□ Irregular Heartbeats □ Blood Clots □ Phlebitis □ Cold Hands □ Cold Feet
□ Swelling Hands □ Swelling Feet □ Other: _____

Gastrointestinal
□ Nausea □ Vomiting □ Diarrhea □ Bowel Movements
□ Gas □ Belching □ Constipation Frequency _____
□ Bad Breath □ Rectal Pain □ Rectal Itch Color _____
□ Hemorrhoids □ Bloody Stools □ Sensitive Abdomen Odor _____
□ Pain or Cramps □ Laxative Use: __/week Type _____ Texture _____

Genitourinary/Prostate
□ Pain w/urination □ Frequent Urination □ Blood in Urine □ Kidney Stones
□ Impotency □ Venereal Disease □ Urgency to Urinate □ Unable to Hold Urine
□ Wake up to Urinate (how often) _____/night What Time? _____ □ Other: _____

GYN/Pregnancy
□ Irregular Periods □ Vaginal Discharge □ Vaginal Sores □ Douche (when) _____
□ Intermenstrual Spotting (when) _____ Last Normal Menstrual Period _____
# of Pregnancies _____ Births _____ Premature Births _____ Miscarriages _____ Age at 1st Menses _____
# of Days in Cycle _____ Period (duration days) _____ Flow (describe) _____
PMS (describe) _____
Menstrual Cramps: □ None □ Mild □ Moderate □ Severe Menopause (when) _____
□ Breast Lumps Birth Control (type and duration) _____
Sexually Transmitted Disease: □ Gonorrhea □ Chlamydia □ Syphilis □ HPV □ HIV □ Herpes
Last Pap Smear _____ □ Abnormal Pap (when) _____
Last Mammogram _____ □ Self Breast Exam (how often) _____

Musculoskeletal
□ Neck Pain □ Muscle Pain □ Back Pain □ Joint Pain Describe Location of Pain _____
□ Loss of Height Last Bone Density Test _____ Other Joint of Bone Problems: _____

Skin and Hair
□ Rashes □ Ulcerations □ Hives □ Itching □ Eczema □ Acne □ Dandruff
□ Hair Loss □ Change in Hair/Skin Texture _____ □ Other: _____

Neuropsychological
□ Seizures □ Areas of Numbness □ Poor Memory □ Depression □ Anxiety □ Concussion
□ Bad Temper □ Easily Stressed □ Suicidal Thoughts □ Suicide Attempts □ Counseling
□ Other Neurological of Psychological Problems: _____