Patient Intake

Name:		Phone: (H/C)	(W)
Address:		Age:	Ht/Wt:
City:		Birthdate:	Sex:
State:	Zip:	Occupation:	
Physician:		Referred by:	Emerg. #:
Main Problem:			Onset:
Other Concurrent Therapies:			

Past Medical History, include date:

- Significant Illnesses: ☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis ☐ Rheumatic Fever ☐ Thyroid Disease ☐ Seizures ☐ Other: _____
- Surgeries:
- Significant Trauma (auto accidents, falls, etc):
- Birth History (prolonged labor, forceps delivery, etc):
- Allergies (drugs, chemicals, foods):
- Medicines taken within the last two months, include vitamins, over the counter drugs, herbs, etc:
- Occupational Stresses (chemical, physical, psychological, etc):
- Exercise:
- Comments:

Daily Diet, what do you eat on an average day:

Morning: _____

Afternoon: _____

Evening: _____

Habits: ☐ Cigarettes ☐ Coffee ☐ Tea ☐ Cola ☐ Alcohol ☐ Drugs ☐ Sugar ☐ Salt ☐ Other: _____

Family History: ☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease ☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐ Alcoholism ☐ Other: _____

Notes: _____

_____

General

☐ Poor appetite ☐ Heavy appetite ☐ Poor sleep ☐ Heavy sleep
☐ Insomnia ☐ Fatigue ☐ Tremors ☐ Vertigo
☐ Cold hands ☐ Cold feet ☐ Cold back ☐ Cold abdomen
☐ Fevers ☐ Chills ☐ Night sweats ☐ Sweat easily
☐ Cravings ☐ Localized weakness ☐ Poor coordination ☐ Changes in appetite
☐ Sudden energy drop at (what time) _____(am/pm) ☐ Peculiar tastes/ smells _____
☐ Strong thirst (cold/hot drinks) _____ ☐ Bleed or bruise easily (where) _____

Notes: _____

_____

Skin and Hair

☐ Rashes ☐ Ulceration ☐ Hives ☐ Itching
☐ Eczema ☐ Pimples ☐ Dandruff ☐ Loss of hair
☐ Change in hair/skin texture ☐ Purpura ☐ Other problems: _____

Notes: _____

_____

Head, Eyes, Ears, Nose, and Throat

☐ Dizziness ☐ Concussions ☐ Migraines ☐ Glasses
☐ Eye strain ☐ Eye pain ☐ Poor vision ☐ Night blindness
☐ Color blindness ☐ Cataracts ☐ Blurry vision ☐ Earches
☐ Ringing in ears ☐ Poor hearing ☐ Nosebleeds ☐ Sinus Problems
☐ Mucus ☐ Dry throat ☐ Dry mouth ☐ Copious saliva
☐ Teeth problems ☐ Jaw clicks ☐ Grinding teeth ☐ Facial pain
☐ Gum problems ☐ Spots in eyes ☐ Recurrent sore throats: _____/ month
☐ Sores on lips or tongue ☐ Other head/neck problems ☐ Headaches (when and where): _____

Notes: _____

_____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pains ☐ Irregular heartbeat
☐ Dizziness ☐ Fainting ☐ Cold hands/feets ☐ Swelling in hands/feet
☐ Blood clots ☐ Phlebitis ☐ Difficulty breathing ☐ Other: _____

Notes: _____

_____

Respiratory

☐ Cough ☐ Coughing blood ☐ Asthma ☐ Bronchitis
☐ Pneumonia ☐ Tight chest ☐ Difficulty in breathing when lying down
☐ Production of phlegm, what color: _____ ☐ Other lung problems: _____

Notes: _____

_____

Gastrointestinal

☐ Nausea ☐ Vomiting ☐ Diarrhea Bowel Movement:
☐ Gas ☐ Belching ☐ Black stools Frequency: _____
☐ Bad breath ☐ Rectal pain ☐ Hemorrhoids Color: _____
☐ Constipation ☐ Bloody stools ☐ Sensitive abdomen Odor: _____
☐ Pain or cramps ☐ Laxative use: _____/week, Type: _____ Texture/form: _____

Notes: _____

_____

Genito-urinary

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine ☐ Urgency to urinate

☐ Unable to hold urine ☐ Kidney stones ☐ Venereal disease ☐ Impotency

☐ Urinary tract infection ☐ Wake up to urinate: how often _____/night, what time _____ ☐ Other G/U problems

Notes: _____

_____

Pregnancy and Gynecology

☐ Number of pregnancies: _____ ☐ Number of births: _____ ☐ Premature births ☐ Miscarriages

☐ Age at first menses: _____ ☐ Period:_____ days ☐ Duration: _____ ☐ Irregular periods

☐ Flow, describe: _____ ☐ Clots Last PAP: _____ Last menses: _____

☐ Vaginal discharge ☐ Vaginal sores ☐ Breast lumps Menopause: _____

☐ Birth control, type: _____ start date: _____ ☐ Changes in body/psyche prior to menstruation

Notes: _____

_____

Musculoskeletal

☐ Neck pain ☐ Muscle pains ☐ Back pain, where: _____

☐ Joint pain, where: _____ ☐ Other joint or bone problems: _____

Notes: _____

_____

Neuropsychological

☐ Seizures ☐ Areas of numbness ☐ Poor memory ☐ Concussion

☐ Depression ☐ Anxiety ☐ Bad temper ☐ Easily stressed

☐ Treated for emotional issues ☐ Considered/attempted suicide ☐ Other neuropsychological issues: _____

Notes: _____

_____

Any other comments: _____

_____

_____

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_____

_____

_____

_____ Date: _____

Painful or Distressed Areas, please note them on diagram: