

## Patient Intake Form

Please take the time to fill out this form completely and accurately. This will better help me assess your health and determine treatment. All answers are confidential.

### Identification

Name \_\_\_\_\_ Sex  M  F Date \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

Telephone: Home \_\_\_\_\_ Work \_\_\_\_\_ Cell \_\_\_\_\_

Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Email \_\_\_\_\_

Single  Married  Partnered  Widowed  Separated/Divorced

Height \_\_\_\_\_ Weight \_\_\_\_\_ Occupation \_\_\_\_\_

Education \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Relationship \_\_\_\_\_

Emergency Contact Telephone \_\_\_\_\_ or \_\_\_\_\_

Name of Physician\* \_\_\_\_\_ Phone number \_\_\_\_\_

Name of counselor/psychologist\* \_\_\_\_\_ Phone number \_\_\_\_\_

Name of Gynecologist\* \_\_\_\_\_ Phone number \_\_\_\_\_

\*No contact will be made without your permission

Your signature \_\_\_\_\_

Special problems or symptoms \_\_\_\_\_

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**Family History** Please complete for each family member, as best as you can, indicating any illnesses that they have ever had. Place an "X" or the date in the appropriate box or boxes.

	Self (date)	Mother	Father	Sibling	Spouse/partner	children
Adopted						
Good health						
Cancer or tumors						
Diabetes						
Thyroid Disorders						
Kidney disorders						
High blood pressure/heart disease/stroke						
Blood or bleeding disorders/anemia						
Seizures						
Allergies						
Alcohol or drug use						
Depression/mental illness						
Hepatitis/liver disorder						
Musculo-skeletal disorder						
HIV/AIDS						
Deceased (age)						

**Personal Lifestyle Habits** For each item, please indicate how much, how many, or how often. Please note if this is current or the date that you quit.

Cigarettes (number per day) \_\_\_\_\_ Coffee/tea (cups per day) \_\_\_\_\_  
 Alcohol (drinks per week) \_\_\_\_\_ Soda \_\_\_\_\_  
 Drug use (recreational) \_\_\_\_\_

Exercise:  yes  no How often \_\_\_\_\_  
 What kind of exercise \_\_\_\_\_

**Medical** If you have ever been hospitalized or in the emergency room for a serious medical illness or operation, please list them below (do not include normal pregnancies).

Year	Operation/Illness
_____	_____
_____	_____
_____	_____
_____	_____

**Medicines** Please list all medications, vitamins, and/or food supplements you are currently taking

Medications _____	Dosage _____	For what condition? _____
_____	_____	_____
_____	_____	_____
_____	_____	_____
Vitamins/Supplements _____	Dosage _____	_____
_____	_____	_____
_____	_____	_____

## Current and Past Conditions/Symptoms/Traumas

If you are currently experiencing any of the following, please mark it with a "C". If you have experienced any of the following in the past, please mark it with a "P". Mark "P-C" if you have experience currently and in the past.

### General

- Insomnia
  - Dreams/nightmares
  - Fatigue
  - Poor memory
  - Strongly like cold drinks
  - Strongly like hot drinks
  - Recent weight loss/gain
  - Cold hands/feet
  - Chills
  - Fever
  - Bad breath
  - Other (describe)
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### Head and Neck

- Headache
  - Migraines
  - Stiff neck
  - Dizziness
  - Fainting
  - Swollen glands
  - Other (describe)
- 

### Ears

- Ringing
  - Hearing loss
  - Hearing aids
  - Infections
  - Earache
  - Vertigo
  - Other (describe)
- 

### Eyes

- Glasses/contacts lenses
  - Blurred vision
  - Poor night vision
  - Spots/floaters
  - Eye inflammation
  - Double vision
  - Glaucoma
  - Cataracts
  - "lazy" eye
  - Other (describe)
- 

### Nose, Throat & Mouth

- Sinus infection
  - Hay fever/allergies
  - Frequent sore throat
  - Difficulty swallowing
  - Mouth & tongue ulcers
  - Frequent colds
  - Nosebleeds
  - Dry nose
  - Nasal congestion
  - Loss of voice
  - Thirst
  - Excessive phlegm
  - TMJ
  - Facial pain
  - Gum problems
  - Dry mouth
  - Other (describe)
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- Dental problems? Last visit?
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### Skin

- Hives
  - Rashes
  - Eczema/psoriasis
  - Night sweating
  - Excess sweating
  - Dry skin
  - Easily bruised
  - Changes in moles/lumps
  - Itching
  - Other (describe)
- 

### Respiratory

- Difficulty breathing
  - Difficulty breathing when reclining
  - Wheezing
  - Asthma
  - Chronic cough
  - Wet cough
  - Dry cough
  - Coughing up phlegm
  - Coughing up blood
  - Shortness of breath
  - Tight chest
  - Pneumonia
  - Other (describe)
- 

### Cardiovascular

- High blood pressure
  - Low blood pressure
  - Chest pain or tightness
  - Palpitation
  - Rapid heart beat
  - Irregular heart beat
  - Poor circulation
  - Swollen ankles
  - Phlebitis
  - Anemia
  - History of heart disease
  - Heart murmur
  - Night sweats
  - Tendency to be cold
  - Tendency to be warm
  - Other (describe)
- 

### Gastrointestinal

- Nausea
  - Indigestion
  - Stomach pain
  - Diarrhea
  - Constipation
  - Poor appetite
  - Excessive hunger
  - Vomiting
  - Gas
  - Hiccups
  - Acid regurgitation
  - Bloating
  - Laxative use
  - Bloody stool
  - Other (describe)
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### Musculoskeletal

- Joint pain/swelling
  - Sore muscles
  - Weak muscles
  - Difficulty walking
  - Pain (describe)
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- Limited range of motion
- Other (describe)
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**Neurological**

- Seizures
- Tremors
- Numbness or tingling
- Pain (describe)

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- Paralysis
- Poor coordination (describe)

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**Mental/Emotional**

- Depression
- Mood swings
- Irritability
- Difficulty relaxing
- Loneliness
- Sensitive
- Shyness
- Frequent crying
- Worries frequently
- Compulsive behaviors
- Difficulty focusing
- Hopeless outlook
- Suicidal thoughts
- Lose temper easily
- Frustration
- Other (describe)

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**Urinary**

- Pain on urination
- Frequent urination
- Urgent urination
- Blood in urine
- Incontinence
- Incomplete urination
- Bedwetting
- Wake to urinate
- History or UTIs
- Kidney (specify)

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- Other (describe)

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**Male Genital**

- Impotence
- Premature ejaculation
- Nocturnal emission
- Pain/itching of genitalia
- Lumps in testicles
- Increased libido
- Decreased libido
- Other (describe)

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**Gynecology**

- Currently pregnant
- # of pregnancies
- # of live births
- #of miscarriages
- #of abortions
- Menopause
- Excessive blood flow
- Menstrual blood clots
- Breast tenderness
- Abnormal pap smear
- Vaginal infections
- Vaginal pain/itching
- Uterine fibroids
- Endometriosis
- Breast lumps/cysts
- Increased libido
- Decreased libido
- Symptoms with menopause (describe)

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- Other (describe)

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**Infection Screening**

- HIV risks: self or partner
- TB: self or household
- Hepatitis risk: self or partner
- History of sexually transmitted diseases:  
self or partner
- Other (describe)

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**Trauma (list)**

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**Other information**

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Patient Signature\_\_\_\_\_

Date\_\_\_\_\_