Name:_____________________________ DOB:_________________ Date__________

Patient Intake Form

What are your goals for today's visit?

What concerns would you like to address?

<u>Your Family's Health History</u> (please list any physical or emotional/behavioral challenges)

Mother:

Father:

Siblings:

Children:

<u>Your Health History</u>

Past problems:

Ongoing or current problems:

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Personal/Social History/Habits

Do you use tobacco? Yes No Type and frequency:

Do you consume alcohol? Yes No Estimated drinks per day: Per week:

Do you use recreational drugs? Yes No Type and frequency:

Do you use caffeine? Yes No Type and frequency:

How is your sleep? Terrible Poor So-so Good Great

Do you feel refreshed when you wake up in the morning? Yes No

What is your occupation?

What are your hobbies and interests?

How do you spend your day?

Have you had any major trauma or abuse in your life?

With whom do you live (include roommates, spouse, children relatives, pets etc.)?

In what physical activities do you participate?

Activity: Frequency: Duration: Intensity:

Or
How do you move your body?

What do you do to relax?

What are the major stressors in your life?

Do you have a meditation, relaxation, spiritual, reflective or centering practice that you do?
If yes, what is it?

What brings you joy?

What gives you a sense of meaning and purpose? If it feels appropriate, describe how spirituality or religion fits into your life or how it has in the past.

What prior experiences have you had with complementary and alternative medicine?

Are you open to it? Yes No

Nutrition information

What did you eat **and** drink in the last 24 hours?
Breakfast:

Lunch:

Dinner:

Snacks:

Is this a typical day? Yes No

Are you currently on a special diet? If so – please describe:

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Review of Systems – Head to Toe (Put a check next to any of the following symptoms or problems you are having)

Fatigue
Difficulty sleeping
Blurry vision
Eye pain
Hearing loss
Ringing in ears
Frequent ear infections
Ear Pain
Frequent canker sores
Palpitations
Chest pain/pressure
Leg swelling
Shortness of breath
Wheezing
Heartburn
Nausea
Vomiting
Abdominal pain
Excessive belching
Excessive passing of gas
Constipation
Diarrhea
Bloating
Frequent urine infections
Urgency to get to the bathroom
Pain with urination
Blood in urine
Leakage of urine
Muscle pain
Muscle cramps or spasms
Tendonitis
Joint pain/stiffness/swelling
Low back pain
Headaches
Dizziness
Balance problems
Weakness/numbness
Tingling sensations
Memory problems
Concentration problems
Seasonal or other allergies
Excessive thirst
Excessive hunger
Cold or heat intolerance
Easy bruising
Rashes
Eczema
Acne
Concerning Moles
Anxiety
Panic attacks
Depression
Suicidal thoughts

Is there anything else that you would like to discuss or comment on?

Completed by:_________________________________ Date:______________________

If not patient, relationship to patient:______________________________________

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