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New Patient In-Take Form

Contact Information (Please print) Date: _____

Name (first & last): _____

Date of Birth: ___/___/_____ Age:_____ Occupation:_____

Address: _____ Apt. #:_____

City: _____ State:_____ Zip Code:_____

E-mail:_____

Home Phone:_____ Cell Phone:_____

In Emergency Notify: Name: _____ Phone:_____

You were referred by: _____

Health Information

Please list your major health complaint(s): _____

_____

To what extent does the problem interfere with your daily activity (work, exercise, sleep, sex, etc.)?

_____

When did the problem begin (be specific): _____

If you have seen a medical doctor, what is your diagnosis? _____

What kind of treatments/therapies have you tried? _____

Past Medical History – please note type and dates:

Cancer: _____ Rheumatic Fever: _____

HIV/AIDS: _____ Hepatitis: _____

Thyroid Disease: _____ Heart Disease: _____

Diabetes:_____ Venereal Disease: _____

High Blood Pressure: _____ Other:_____

Asthma: _____

Surgeries (type & dates): _____

Significant Traumas:_____

Significant Dental Work:_____

Allergies (drugs, chemicals, foods, etc.):_____

_____

Stress (occupational, chemical, physical, psychological):_____

_____

Birth History (prolonged labor, forceps, premature, etc.)_____

Family Medical History

Cancer	Heart Disease	Asthma
Diabetes	Stroke	Allergies
High Blood Pressure	Seizures	Other

_____

Medications

What medications and/or supplements are you currently taking?_____

_____

_____

Habits

Do you have a regular exercise program? Please describe: _____

_____

Are you or have you been on a restricted diet? What kind and why? _____

_____

Please describe your average daily diet (including liquids):

Morning: _____

Afternoon:_____

Evening: _____

Current Health Condition: please circle symptoms which you have experienced in the past 3 months

Energy, Immunity, and Temperature

Fatigue	Catch colds easily	Sweat easily	Cold hands/feet
Energy drops	Slow wound healing	Night sweats	
General weakness	Chronic infections	Chills	

Overall Body Temperature: _____ Overall Energy Level_____

Head, Eye, Ear, Nose, and Throat

Headache/Migraine	Eye strain/pain	Nasal congestion	Hoarseness
Dizziness/Vertigo	Ear ringing	Teeth grinding	Swollen glands
Blurry vision	Earaches	TMJ/Jaw problems	
Floaters	Sinus problems	Snoring	
Photosensitivity	Nose bleeds	Sore throat	

Respiratory

Asthma/Wheezing	Cough	Allergies
Phlegm	Shortness of breath	

Cardiovascular

Palpitations	High cholesterol	Chest pain
High blood pressure	Fainting	Varicose veins

Gastrointestinal

Low appetite	Bloating	Belching	Constipation
Excessive appetite	Heartburn	Stomach growling	Hemorrhoids
Bad breath	Ulcers	Diarrhea	Abdominal pain
Nausea/Vomiting	Gas	Loose stools	Gallbladder stone

Genito-urinary

Pain/Burning on urination	Waking at night to urinate	Kidney Stones
Urinary urgency	Dribbling urination	Blood in urine
Frequent urination	Profuse urination	Urinary tract infections
Incontinence	Retention of urine	

Neuro-muscular

Seizures	Lack of coordination	Poor memory	Numbness/Tingling
Paralysis	Loss of balance	Poor concentration	Muscle spasms

Sleep

Trouble falling asleep	Tired upon waking	Nightmares
Trouble staying asleep	Excessive dreaming	

What hour do you go to sleep?_____ What hour do you wake up?_____

Emotions

Mood swings	Anxiety/Panic attacks	Fits of laughter
Sadness	Irritability/Anger	Depression
Nervousness	Mania/Highly elevated mood	Obsessive/Compulsive
Fear	Frequent worrying	

Skin and Hair

Acne	Itching	Rashes	Bruising easily
Dandruff	Dry skin/scalp	Hair loss	Sores

Bowel Movements:

Frequency: _____ Feels complete? Yes No

Consistency:	Well-formed	Hard	Loose	Alternates
Stools:	Undigested food	Blood	Mucus	

Men Only: Please check all that apply

Prostate disease	Low sperm count	z Premature ejaculation
Testicular pain	Poor sperm motility	Nocturnal emissions
Low sex drive	Irregular sperm morphology	
Impotence		Other_____

Women Only:

At what age did you get your first period: _____ First day of last menstrual period: _____

Are you currently using birth control Yes No What type and for how long? _____

Is there any chance you are pregnant now? Yes No

Are your menstrual cycles spaced regularly? Yes No

Length of cycle: _____ Length of menstrual period: _____

Do you experience any of the following associated with your period each month?

Water retention
Breast tenderness or swelling
Mood swings
Irritability
Food cravings
Migraines
Changes in bowel movements
Abdominal cramps
Lower back pain
Acne
Heavy bleeding
Scanty bleeding
Clots
Other:_____

Do you experience any of the following?

Infertility
Abnormal vaginal discharge
Abnormal pap smear
Spotting between periods
Hot flashes
Low sex drive
Pain during intercourse
Vaginal dryness
Other_____

Number of pregnancies: _____ Number of abortions: _____

Number of miscarriages: _____ Number of live births: _____

Have you experienced menopause? Yes No When? _____

If you are experiencing menopausal symptoms, please describe: _____

_____

_____

Signature *Date*