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PATIENT INTAKE FORM File No. . . . . .

Date: . . . . . .

Name: . . . . . D.O.B . . . . . Age . . . . .
Marital status: . . . . . Sex: . . . . . Occupation: . . . . . .
Address:. . . . . Children: . . . . . .
. . . . . Referred by: . . . . . .
Telephone: H: . . . . . W: . . . . . E-mail . . . . . .
GP's Name & Address . . . . . .
Height: . . . . . Weight: . . . . . Weight 1 year ago: . . . . . .
Maximum weight: . . . . . When: . . . . . .

Have you experienced the following? If in the past please indicate approximate year in column 1; if current, mark column 2

1. **Skin**	P	C
Rashes		
Eczema, hives		
Acne, boils, ulcers		
Itching skin		
Skin color change		
Lumps		
Night sweats		
Dry/moist skin		
Hot/cold skin		
Nail changes		
Change in a mole		
Skin cancer		

2. **Eyes**		
Vision problems		
Glasses/contacts		
Eye pain, itching		
Tearing/dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Sensitive to light		
Discharge		
Redness		
Blind spot		

3. **Cardiovascular**		
Heart disease		
Angina		
High blood pressure		
Murmurs		
Rheumatic fever		
Chest pain/pressure		
Swelling in ankles		
Palpitations		
Rapid heart rate		
Cyanosis		
Weakness		

4. **Head**	P	C
Headache		
Migraine		
Head injury		
Dizziness		

5. **Ears**		
Reduced hearing		
Earache		
Ear Infections		
Ear discharge		
Tinnitus		
Poor balance		

6. **Mouth & Throat**		
Frequent sore throat		
Sore tongue/mouth		
Bleeding/sore gums		
Hoarseness		
Dental cavities		
Loss of taste		
TMJ		
Voice changes		

7. **Neck**		
Lumps		
Swollen glands		
Goiter		
Neck pain/stiffness		

8. **Musculoskeleal**		
Joint pain/stiffness		
Arthritis		
Broken bones		
Spasms or cramps		
Joint swelling		
Backache/pain		
Weakness		
Weak/sore knees		

9. **Hospitalizations**	

10. **Nose & Sinuses**	P	C
Fever/chills		
Frequent colds, flu		
Nose bleeds		
Stuffiness		
Hay fever		
Sinus problems		
Post-nasal drip		
Loss of smell		

11. **Respiratory**		
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficult breathing		
Painful breathing		
Shortness of breath		
Shortness of breath at night		
Shortness of breath lying down		
Tuberculosis		
Tuberculin test		
Last chest x-ray		

12. **Peripheral vascular**		
Deep leg pain		
Cold hands/feet		
Varicose veins		
Thrombophlebitis		
Leg cramps		
Extremity numbness		
Extremity swelling		
Extremity ulcers		

13. **Vehicle accidents** injuries:

14. **Gastrointestinal**	P	C
Heartburn		
Trouble swallowing		
Change in thirst		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Constipation		
Diarrhea		
Blood in stool		
Jaundice		
Liver disease		
Gall bladder		
Ulcer		
Indigestion		
Rectal bleeding		
Hemorrhoids		
Black, tarry stool		
Abdominal pain		
Food allergy		
Hernia		

15. **Blood/Lymphatic**	
Anemia	
Bleeding/bruising	
Lymph node swelling	

16. **Emotional**	
Depression	
Mood swings	
Nervousness	
Anxiety	
Tension	
Stress	
Phobias	
Restlessness	

Rate general stress level out of 10, 10 being the highest

17. **Urinary** P C
Pain on urination
Increased frequency
Frequency at night
Can't hold urine
Frequent infections
Kidney stones
Blood in urine
Urgency
Hesitancy
Discharge

Prescription drugs (list on reverse)

18. **Neurological** P C
Fainting
Seizures/convulsions
Paralysis
Muscle weakness
Numbness or tingling
Loss of memory
Involuntary movement
Loss of balance
Speech problems
Insomnia

Over-the-counter meds (list on reverse)

19. **Endocrine** P C
Heat/cold intolerance
Thyroid problems
Excessive thirst
Excessive hunger
Cravings
Excessive urination
Excessive sweating
Diabetes
Hypoglycemia
Hormone therapy

Supplements (list on reverse)

20. **Allergies or Drug sensitivity** P C
Please list:

21. **Liver/Gall Bladder**
Irritated easily
Slow digestion
Bitter taste in mouth
Low energy/stamina
Brittle nails
Sweaty palms
Sweats easily

22 . **Immunizations:** DPT MMR Polio Flu Other

23. **Male:**
Erectile dysfunction
Low sex drive
Hernias
Testicular masses
Testicular pain
Sexually active
Exposure to STDs
Discharge or sores

23. **Female:**
Age menses began
Average # of days
Length of cycle
Last period began
Are cycles regular
Bleeding mid-cycle
Painful menses
Excessive flow
Pain during intercourse
PMS
Low sex drive

Birth control type
Difficulty conceiving
No. of pregnancies
Number of live births
No. of miscarriages
No. of abortions
Vaginal itching
Vaginal discharge
Last PAP test date
Date of last period:
Hot flashes

Male & Female
Sexually active
Exposure to STDs
Sexual preference:
Heterosexual
Bisexual
Homosexual
Breast self-exam
Lumps
Pain/tenderness
Nipple discharge

Do you eat three meals daily?
Do you average 6 to 8 hours sleep?
Do you sleep well? fall asleep easily?
Do you wake refreshed?
Do you enjoy your work?
How many hours of television do you watch daily?
Do you read for pleasure?
What are your main interests or hobbies?
General energy level? low medium high

Do you exercise? How often?
What form? How long?
Do you take vacations? Tropical destinations
Do you smoke How much?
Do you use alcohol? Frequency?
What type?
Have you ever been treated for alcoholism/drug use?
Do you use recreational drugs?
Have you ever used recreational drugs?
which ones?

24. **Family Medical History:** Has anyone in your family ever had the following? Please indicate relationship.

Heart Disease
Allergies
Arthritis
Depression
Cancer What type?

High blood pressure
Asthma
Low/high thyroid
Mental illness

Stroke
TB
Kidney disease
Diabetes
Epilepsy

Alzheimer's
Emphysema
Digestive upsets
Anemia
Other

Please note any medical problems of close family members

	Age	Health Problems	If deceased, age at and cause of death
Father			
Mother			
Brothers			
Sisters			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Other			