Patient Intake Form

Name: _____ Date: _____

Address: _____

City: _____ State: ____ Zip _____ Date of Birth: _____

Telephone: Hm _____ Wk _____ Cell: _____

Email: _____ Emergency Contact: _____

Previous names used:_____ Sex: Male _____ Female _____

Employer: _____ Occupation: _____

Education: (indicate highest level completed)

___ grade school ___ high school ___ some college ___ college grad ___ grad school ___ grad degree

Marital status: (check one)

___ single ___ married ___partnered ___ widowed ___ separated ___ divorced

Living with: (check one)

___ alone ___ spouse ___partner ___ family ___ roommate(s) ___ other

How did you hear about us? _____

What are your major health concerns?

1. _____
2. _____
3. _____

Was your PRIMARY problem diagnosed by a physician? ___ yes ___ no

How long have you had the primary problem? _____

What treatments have you tried for your primary problem? _____

_____

_____

Are you taking any medications for your primary problem? ___ yes ___ no

If yes, please list _____

Are you taking any other medications? ____ yes ____ no

If yes, please list _____

_____

Are you taking any vitamins or other supplements? ____ yes ____ no

If yes, please list: _____

_____

Do you have any allergies **to medications or substances? ____ yes ____ no**

If yes, please list _____

_____

_____

_____

Circle the answer that best reflects the frequency of each symptom
0 = never 1 = seldom 2 = occasional 3 = often

CONSTITUTION
Part A: GENERAL
1. Height _____'_____"
2. Weight _____lbs
3. Frequent illness 0 1 2 3
4. Dizziness 0 1 2 3

Part B: SLEEP
1. Insomnia 0 1 2 3
2. Restless legs when laying down 0 1 2 3
3. Using a sleep aid? No Yes

EYES
1. Watery / itchy eyes 0 1 2 3
2. Dry / reddened eyes 0 1 2 3
3. Blurred, tunnel, double vision 0 1 2 3
4. Eye pain / fatigue 0 1 2 3

EARS, NOSE, MOUTH, THROAT
1. Itchy ears 0 1 2 3
2. Frequent pain / infections 0 1 2 3
3. Ringing / hearing loss 0 1 2 3
4. Stuffy nose / sinus problems 0 1 2 3
5. Hoarseness, loss of voice 0 1 2 3
6. Canker sores 0 1 2 3

CARDIOVASCULAR SYSTEM
1. Chest pain/left arm pain/numbness 0 1 2 3
2. Shortness of breath during minor activity 0 1 2 3
3. Pain in shoulder or jaw (circle which) 0 1 2 3
4. Swelling of feet and ankles 0 1 2 3
5. Blood pressure higher than 120/80? No Yes

RESPIRATORY SYSTEM
1. Difficulty breathing / asthma 0 1 2 3
2. Chest tightness / pain / congestion 0 1 2 3
3. Recurring/chronic cough 0 1 2 3

DIGESTIVE SYSTEM
Part A: GENERAL DIGESTIVE SYSTEM
1. Nausea/vomiting 0 1 2 3
2. Recent change in appetite 0 1 2 3
3. Blood in stool 0 1 2 3
4. Bowel movements how often? _____/day

Part B: DIGESTION
Part B-1: DIGESTION: LOW ACIDITY
1. Indigestion 0 1 2 3
2. Constipation 0 1 2 3
3. Belching / burping / 0 1 2 3
4. Food sits in stomach, undigested 0 1 2 3
5. Undigested food in stools 0 1 2 3
6. Do you have food sensitivities? No Yes

Part B-2: DIGESTION: HIGH ACIDITY
1. Stomach pains 1-4 hours after meals 0 1 2 3
2. Stomach pain relieved by milk/cream 0 1 2 3
3. Heartburn lying down or bending fwd 0 1 2 3
4. Constant need for antacids 0 1 2 3
5. Ulcer ? No Yes

PART C: ASSIMILATION
Part C-1: SMALL INTESTINE
1. Abdominal cramps, pain, bloating, gas 0 1 2 3
2. Soft, pasty or unformed stool 0 1 2 3
3. Fiber rich diet causes constipation 0 1 2 3
4. Mucus in stool, greasy stool 0 1 2 3
5. Stools have foul odor 0 1 2 3
6. Frequent urination 0 1 2 3
7. Increased thirst and appetite 0 1 2 3

Part C-2: LARGE INTESTINE (COLON)
1. Diarrhea / constipation (circle) 0 1 2 3
2. Frequent abdominal cramps 0 1 2 3
3. Fingernail/toenail fungus/vag yeast infx 0 1 2 3
4. Coated or fuzzy tongue 0 1 2 3
5. Flatulence (gas) 0 1 2 3
6. Use of antibiotics in the past year? No Yes

PART D: LIVER / GALLBLADDER
1. Abdominal pain after eating fatty food 0 1 2 3
2. Painful or tender big toe 0 1 2 3
3. Hard, dry stool 0 1 2 3
4. Stool color is gray or light 0 1 2 3
5. Skin itches 0 1 2 3
6. Headaches following meals 0 1 2 3
7. Dry or flaky skin or hair 0 1 2 3
8. Yellow sclera (white of the eyes) 0 1 2 3
9. Bad breath or body odor 0 1 2 3
11 Impatient, irritated, easy to anger 0 1 2 3
12 Red or dry eyes 0 1 2 3
13 Have had jaundice or hepatitis? No Yes
14 High cholesterol and/or low HDL? No Yes

URINARY SYSTEM
1. Pain on urination 0 1 2 3
2. Frequent urination 0 1 2 3
3. Constant feeling of a full bladder 0 1 2 3
4. Loss of control holding urine 0 1 2 3
5. Drip/dribble after urination 0 1 2 3
6. Straining to urinate with scant passage 0 1 2 3
7. Awaken during night to urinate 0 1 2 3
8. History of bladder infection/cystitis? No Yes

MUSCULOSKELETAL
Part A: BONE INTEGRITY
1. Pain in joints 0 1 2 3
2. Gingivitis/gum sensitivity No Yes
3. Osteopenia/Osteoporosis? No Yes
4. Bone fracture in past two years? No Yes

Part B: MUSCLE
1. Frequent muscle cramps / spasms 0 1 2 3
2. Stiff upon awakening / after sitting 0 1 2 3
3. Feeling of weakness / tiredness 0 1 2 3
4. Fibromyalgia? No Yes

Part C: CONNECTIVE TISSUE
1. Injured tendons / ligaments 0 1 2 3
2. Lax ligaments / joint instability 0 1 2 3
3. Tendonitis / bursitis 0 1 2 3
4. Slipped / herniated disc? No Yes

SKIN

1. Acne / boils (circle) 0 1 2 3
2. Hives / rash / dry skin (circle) 0 1 2 3
3. Color change 0 1 2 3
4. Lumps / bumps / outbreaks 0 1 2 3
5. Unexplained broken capillaries/bruising 0 1 2 3

NERVOUS SYSTEM

1. Numbness / tingling 0 1 2 3
2. Diminished ability to feel calm, relaxed 0 1 2 3
3. Convulsions / seizures 0 1 2 3
4. Poor memory / concentration 0 1 2 3
5. Imbalance of up and down moods 0 1 2 3
6. Paralysis / loss of motor control No Yes

ENDOCRINE

Part A: ADRENAL

1. Cannot stay asleep 0 1 2 3
2. Crave salt 0 1 2 3
3. Energy low in morning to mid-afternoon 0 1 2 3
4. Dizzy / light headed upon standing 0 1 2 3
5. Catch colds or get sick easily 0 1 2 3
6. Weak nails 0 1 2 3
7. Perspire easily/ warm episodes 0 1 2 3
8. Eyes sensitive to bright/direct light 0 1 2 3
9. Past use of cortisone, prednisone 0 1 2 3

PART B: THYROID

Part B-1: Hypothyroid

1. Hands and feet are cold 0 1 2 3
2. Constantly tired / fatigued 0 1 2 3
3. Lack of stamina / motivation 0 1 2 3
4. Skin is dry 0 1 2 3
5. Especially tired in the later part of day 0 1 2 3
6. Constipation 0 1 2 3
7. Outer third of eyebrow thins 0 1 2 3
8. Morning headaches that wear off 0 1 2 3
9. Gain wt easily in spite of little food No Yes

Part B-2: Hyperthyroid

1. Heart palpitations 0 1 2 3
2. Increased pulse even at rest 0 1 2 3
3. Insomnia 0 1 2 3
4. Night sweats 0 1 2 3
5. Eyes appear to bulge or be swollen 0 1 2 3
6. Difficulty gaining weight 0 1 2 3

Part C: PANCREAS:

Part C-1 LOW BLOOD SUGAR

1. Strong desire for sweets and fats 0 1 2 3
2. Sweets / alcohol relieve headaches fast 0 1 2 3
3. Irritable if a meal is missed or late 0 1 2 3
4. Frequently drowsy, impatient, moody 0 1 2 3
5. Need caffeine to get going 0 1 2 3
6. Hungry 1-3 hours after eating 0 1 2 3
7. Feel shaky, weak or fatigued 0 1 2 3
8. Feel better / calmer after eating? No Yes

Part C-2 INSULIN RESISTANCE

1. Increased thirst & appetite 0 1 2 3
2. Eating sweets does not alleviate cravings 0 1 2 3
3. Must have sweets after meals 0 1 2 3
4. Waist girth equal or greater than hip 0 1 2 3
5. Fatigue after meals 0 1 2 3
6. Family history of diabetes? No Yes
7. Difficulty losing weight No Yes

LYMPHATIC/BLOOD

1. Need to clear throat, especially in AM 0 1 2 3
2. Swelling in throat / neck 0 1 2 3
3. Skin irritation / rash 0 1 2 3
4. Nodules or tenderness in breasts 0 1 2 3
5. Swelling in feet or ankles upon waking 0 1 2 3
6. Puffiness beneath eyes in the morning 0 1 2 3

IMMUNE SYSTEM

Part A: LOW-FUNCTIONING

1. Runny nose 0 1 2 3
2. Nose bleeds for no apparent cause 0 1 2 3
3. Frequent chest and throat infections 0 1 2 3
4. Lymph glands swell 0 1 2 3
5. Ear infection/congestion 0 1 2 3
6. Slow recovery from cold or flu 0 1 2 3

Part B-1: HYPER-REACTIVE/CYTOKINE STORM

1. Food sensitivity / allergy 0 1 2 3
2. Swallowing tablets is difficult 0 1 2 3
3. Migraine headaches 0 1 2 3
4. Low grade fever from time to time 0 1 2 3
5. Achy flu-like feeling 0 1 2 3
6. Bed wetting 0 1 2 3
7. Attention deficit, hyperactivity 0 1 2 3

FEMALE

Part A: FEMALE, GENERAL

1. Sexual difficulties 0 1 2 3
2. Pain during intercourse 0 1 2 3
3. Sexually transmitted disease 0 1 2 3
4. Vaginal itching / discharge 0 1 2 3
5. Do you use birth control? No Yes

Part B: SYMPTOMS DURING MENSTRUATION

1. Monthly weight gain 0 1 2 3
2. Premenstrual breast pain or discomfort 0 1 2 3
3. Moodiness / irritability / anger 0 1 2 3
4. Bloating / swelling 0 1 2 3
5. Nausea / vomiting (circle which) 0 1 2 3
7. Monthly headaches tracking cycle 0 1 2 3
8. Suicidal feelings? No Yes

Part C: PAINFUL MENSTRUATION

1. Bleeding between periods 0 1 2 3
2. Irregular cycles 0 1 2 3
3. Muscle cramps / pain during cycles 0 1 2 3
4. Heavy menstrual bleeding 0 1 2 3
5. Must lie down first days of period 0 1 2 3

Part E: HORMONAL BALANCE

1. Hot, sweaty flashes / flushes 0 1 2 3
2. Night sweats 0 1 2 3
3. Mood swings / depression 0 1 2 3
4. Insomnia / light sleep 0 1 2 3
5. Heavy, extended bleeding 0 1 2 3
6. Vaginal dryness 0 1 2 3
7. Low or no desire for sex (libido)? No Yes

MALE

1. Fatigue in legs or lower back 0 1 2 3
2. Pain or discomfort upon ejaculation 0 1 2 3
4. Sexually transmitted disease? No Yes
5. Testicular masses, pain? No Yes
6. Sexual difficulties? 0 1 2 3
7. Decreased libido / sex drive 0 1 2 3

LIFESTYLE: A = Always U = Usually O = Often S = Sometimes N = Never

1. Eat 3 meals a day? A U S N
2. Do you exercise? O S N
   How often? _____ times/week
   What forms? _____
   _____
3. Do you drink coffee? O S N
   How much? _____ cups/day
4. Do you drink black tea? O S N
   How much? _____ cups/day
5. Do you drink soda? O S N
   How much? _____ cans/day
6. Do you use recreational drugs? O S N
   How often? _____ times/week
7. Do you use tobacco now? O S N
   What forms? _____
   How much? _____amount/number/day
8. Did you use tobacco in the past? O S N
   What forms? _____
   How much? _____amount/number/day
   How long? _____
   When stopped? _____Mo/_____Yr

Please list **hospitalizations** or surgeries that you have had

_____
_____
_____
_____-
_____

What **immunizations** have you had? Check = immunization received. "?" = do not know.

____ Polio
____ Tetanus shot (not antitoxin)
____ Measles/Mumps/Rubella
____ Pertussis
____ Diptheria
____ Other: _____

SELF AND FAMILY HISTORY

Please indicate if a member of your family has had the following conditions by checking the appropriate boxes:

	Father	Mother	Brothers	Sisters	Grandfathers	Grandmothers
Allergies	☐	☐	☐	☐	☐	☐
Asthma	☐	☐	☐	☐	☐	☐
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Gallbladder Disease	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
High Blood Pressure	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Kidney Stone(s)	☐	☐	☐	☐	☐	☐
Mental Illness	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Stroke	☐	☐	☐	☐	☐	☐

Please indicate if you have ever had the following conditions by checking either yes or no:

Condition	YES	NO	Condition	YES	NO	Condition	YES	NO
Anemia	☐	☐	Glaucoma	☐	☐	Mental illness	☐	☐
Arthritis	☐	☐	Head injury	☐	☐	Osteopenia/porosis	☐	☐
Asthma	☐	☐	Heart disease	☐	☐	Pneumonia	☐	☐
Cancer	☐	☐	Hemorrhoids	☐	☐	Rheumatic fever	☐	☐
Cataracts	☐	☐	High blood pressure	☐	☐	Stroke	☐	☐
Diabetes	☐	☐	Hypothyroid	☐	☐	Thrombophlebitis	☐	☐
Emphysema	☐	☐	Kidney disease	☐	☐	Tuberculosis	☐	☐
Epilepsy	☐	☐	Kidney stone(s)	☐	☐	Ulcer	☐	☐
Gallbladder disease	☐	☐	Learning disability	☐	☐	Vericose veins	☐	☐