**Patient Intake Form**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Surname) (First) (Initial)***

Date of birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: □ Male □ Female

  ***(day/month/year)***

Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Contact Information:

***\* Please inform the clinic if your contact information changes\****

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***( Street and number) (City) (Postal Code)***

Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  ***(Daytime) (Evening) (Fax)***

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Name) (Relationship)***

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Daytime phone number) (Evening phone number)***

How did you hear about our clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your Health Care Providers:

Who is your primary

care physician ? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Name) (Phone Number)***

When was your last

physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Month) (Year)***

Are you currently under the care of a specialist?

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Name) (Phone Number)***

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (***Name) (Phone Number)***

Are you currently under the care of an alternative healthcare provider (e.g., acupuncturist, chiropractor, registered massage therapist)?

1) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

  ***(Name) (Phone Number)***

2) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 ***(Name) (Phone Number)***

**Health Concerns;**

Please list any health concerns in order of importance:

1)

 ***(Describe your condition)***

 When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has this condition been diagnosed? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2)

 ***(Describe your condition)***

 When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has this condition been diagnosed? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3)

  ***(Describe your condition)***

 When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has this condition been diagnosed? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4)

 ***(Describe your condition)***

 When did it start? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Has this condition been diagnosed? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5)

***(Describe your condition)***

 When did it start?

 Has this condition been diagnosed? Yes No \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

What medications are you currently taking? Your list should include: **prescription** and **over-the-counter drugs; birth control pills, herbal remedies, vitamins** and **other supplements.**

|  |  |  |
| --- | --- | --- |
| Pharmaceutical drug or supplement (for supplements, please include the brand) | How much do you take per day? | Why are you taking the medications? |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Have you ever used or been treated with any of the following?

***(Please check the following)***

* Antibiotics for more than 2 week
* Cortisone or other steroids
* Antihistamines
* Drugs for arthritis (Vioxx, Celebrex)
* Thyroid Medications
* Laxatives or stool softeners
* Anti-depressants
* Flu vaccinations
* Vaccinations for foreign travel
* Sleeping pills or sedative
* Antacids
* Chemotherapy/radiation
* Pain relievers (aspirin, ibuprofen)
* Hormone therapy (including fertility treatments)
* Recreational drugs
* Blood thinners
* Stimulants
* Diuretics

Adverse reactions to medications: Please describe any adverse reactions you had to

* Prescription drugs, over-the-counter drugs or recreational drugs
* Vaccinations (childhood, travel, flu, hepatitis)
* Natural medicines (herbs, vitamins, minerals, homeopathics)

|  |  |
| --- | --- |
| Name of drug, vaccine or natural medicine | Describe the reaction |
| 1) |  |
| 2) |  |
| 3) |  |

**Medical History**

Please list any allergies or sensitivities (***food, pollen, mold, minerals, chemicals***) you suffer from or have previously experienced.

|  |  |
| --- | --- |
| Allergy | Age of onset |
|  |  |
|  |  |
|  |  |

Please list surgeries and/or hospitalizations you have had.

|  |  |  |
| --- | --- | --- |
| Reason/Procedure | Year  | Outcome |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |
|  |  |  |

Do you frequently use any of the following? (Please check if indicated)

* Alcohol – how much/day or week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Tobacco- form and amount/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Caffeine- form and amount/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
* Recreational drugs- what and how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you get regular screening tests done by another doctor? (Pap, blood tests etc)? Yes/No

Do you have any dietary restrictions? (vegetarians, religious, allergies) Yes/No

If yes, please state them \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Environment**

Toxin Exposure

|  |  |  |
| --- | --- | --- |
| Have you ever been exposed to mold, solvents, lead, paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations) at work or while traveling? | Y | N |
| Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide? | Y | N |
| Are you particularly sensitive to perfume, gasoline or other vapors? | Y | N |
| Have you ever lived near a refinery or a polluted area? | Y | N |
| Have you ever lived in a house /apartment more than 50 years old? | Y | N |

How would you describe the emotional climate of your home?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How stress is your work, or other aspects of your life? How well do you handle these stresses?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Do you exercise regularly? □ Yes □ No If yes, what do you do for exercise, how much, how often?

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