

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Intake form, 1



Welcome. Our philosophy and approach to medicine is wholistic and seeks to understand all factors that may be affecting your health. This intake form will help us to uncover the underlying causes of your health concerns. If any of these questions are difficult for you to answer, please let your physician know. Please complete this form and if possible, mail or bring it to our office prior to your

Name:		Today's Date:	
Date of Birth:		Age:	

### HEALTHCARE PROVIDERS

Who is your PCP?	Name:	Location:
Last physical exam?	Month/Year:	
Who is your OB/GYN?	Name:	Location:
Last GYN exam?	Month/Year:	
Who is your dentist?	Name:	Location:
Last visit to the dentist?	Month/Year:	
Who is your optometrist?	Name:	Location:
Last eyesight check?	Month/Year:	
<b>Are you currently under the care of a specialist of any kind (ie - gastroenterologist, acupuncturist, counselor?)</b>		
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:

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Intake form, 2

## HEALTH CONCERNS

Please list your main concerns in order of importance. Describe each condition. Estimate start date of condition.

### 1 | Condition/Start date

Has this condition been diagnosed?  yes  no if yes, as what?: \_\_\_\_\_

Are you receiving treatment of any kind for this condition? Please describe: \_\_\_\_\_  
\_\_\_\_\_

### 2 | Condition/Start date

Has this condition been diagnosed?  yes  no if yes, as what?: \_\_\_\_\_

Are you receiving treatment of any kind for this condition? Please describe: \_\_\_\_\_  
\_\_\_\_\_

### 3 | Condition/Start date

Has this condition been diagnosed?  yes  no if yes, as what?: \_\_\_\_\_

Are you receiving treatment of any kind for this condition? Please describe: \_\_\_\_\_  
\_\_\_\_\_

### 4 | Condition/Start date

Has this condition been diagnosed?  yes  no if yes, as what?: \_\_\_\_\_

Are you receiving treatment of any kind for this condition? Please describe: \_\_\_\_\_  
\_\_\_\_\_

### 5 | Condition/Start date

Has this condition been diagnosed?  yes  no if yes, as what?: \_\_\_\_\_

Are you receiving treatment of any kind for this condition? Please describe: \_\_\_\_\_  
\_\_\_\_\_

Please list other important Past Medical Health Concerns: \_\_\_\_\_  
\_\_\_\_\_

What do you hope to accomplish in your visit? \_\_\_\_\_  
\_\_\_\_\_

When was the last time that you felt well? \_\_\_\_\_  
\_\_\_\_\_

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Intake form, 3

### PAST MEDICAL CONDITIONS

Conditions/Diagnosis (Check appropriate box and provide date of onset) P = past, O = ongoing		
Gastrointestinal		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Irritable Bowel Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Inflammatory Bowel Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Crohn's	
<input type="checkbox"/> P <input type="checkbox"/> O	Ulcerative Colitis	
<input type="checkbox"/> P <input type="checkbox"/> O	Gastritis or Ulcer	
<input type="checkbox"/> P <input type="checkbox"/> O	GERD (reflux)	
<input type="checkbox"/> P <input type="checkbox"/> O	Celiac disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Other _____	
Cardiovascular		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Heart Attack	
<input type="checkbox"/> P <input type="checkbox"/> O	Other Heart Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Stroke	
<input type="checkbox"/> P <input type="checkbox"/> O	Elevated cholesterol	
<input type="checkbox"/> P <input type="checkbox"/> O	Arrythmia	
<input type="checkbox"/> P <input type="checkbox"/> O	Hypertension	
<input type="checkbox"/> P <input type="checkbox"/> O	Rheumatic Fever	
<input type="checkbox"/> P <input type="checkbox"/> O	Mitral Valve Prolapse	
<input type="checkbox"/> P <input type="checkbox"/> O	Other _____	
Cancer		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Lung cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Breast cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Colon cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Ovarian cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Prostate cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Skin cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Other _____	
Genital/Urinary		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Kidney stones	
<input type="checkbox"/> P <input type="checkbox"/> O	Gout	
<input type="checkbox"/> P <input type="checkbox"/> O	Interstitial Cystitis	
<input type="checkbox"/> P <input type="checkbox"/> O	Frequent Urinary Tract Infections	
<input type="checkbox"/> P <input type="checkbox"/> O	Frequent Yeast Infections	
<input type="checkbox"/> P <input type="checkbox"/> O	Erectile/Sexual Dysfunction	
<input type="checkbox"/> P <input type="checkbox"/> O	Other _____	
Musculoskeletal		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Osteoarthritis	
<input type="checkbox"/> P <input type="checkbox"/> O	Fibromyalgia	
<input type="checkbox"/> P <input type="checkbox"/> O	Chronic pain	
<input type="checkbox"/> P <input type="checkbox"/> O	Other _____	
Inflammatory/Immune		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Chronic Fatigue Syndrome	
<input type="checkbox"/> P <input type="checkbox"/> O	Autoimmune Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Rheumatoid Arthritis	
<input type="checkbox"/> P <input type="checkbox"/> O	Lupus SLE	
<input type="checkbox"/> P <input type="checkbox"/> O	Immune Deficiency Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Genital Herpes	
<input type="checkbox"/> P <input type="checkbox"/> O	Severe Immune Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Frequent Infections	
<input type="checkbox"/> P <input type="checkbox"/> O	Food Allergies	
<input type="checkbox"/> P <input type="checkbox"/> O	Environmental Allergies	
<input type="checkbox"/> P <input type="checkbox"/> O	Multiple Chemical Sensitivities	
<input type="checkbox"/> P <input type="checkbox"/> O	Latex Allergy	
<input type="checkbox"/> P <input type="checkbox"/> O	Other _____	

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### PAST MEDICAL CONDITIONS-CONTINUED

Conditions/Diagnosis (Check appropriate box and **provide date of onset**) P = past, O = ongoing

Metabolic/Endocrine		Date of Onset	Respiratory		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Type 1 Diabetes		<input type="checkbox"/> P <input type="checkbox"/> O	Asthma	
<input type="checkbox"/> P <input type="checkbox"/> O	Type 2 Diabetes		<input type="checkbox"/> P <input type="checkbox"/> O	Chronic Sinusitis	
<input type="checkbox"/> P <input type="checkbox"/> O	Hypoglycemia		<input type="checkbox"/> P <input type="checkbox"/> O	Bronchitis	
<input type="checkbox"/> P <input type="checkbox"/> O	Metabolic Syndrome		<input type="checkbox"/> P <input type="checkbox"/> O	Emphysema	
<input type="checkbox"/> P <input type="checkbox"/> O	Hypothyroidism		<input type="checkbox"/> P <input type="checkbox"/> O	Pneumonia	
<input type="checkbox"/> P <input type="checkbox"/> O	Hyperthyroidism		<input type="checkbox"/> P <input type="checkbox"/> O	Tuberculosis	
<input type="checkbox"/> P <input type="checkbox"/> O	Endocrine Problems		<input type="checkbox"/> P <input type="checkbox"/> O	Sleep Apnea	
<input type="checkbox"/> P <input type="checkbox"/> O	Polycystic Ovarian Syndrome		<input type="checkbox"/> P <input type="checkbox"/> O	Other_____	
<input type="checkbox"/> P <input type="checkbox"/> O	Infertility		Skin		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Weight gain		<input type="checkbox"/> P <input type="checkbox"/> O	Eczema	
<input type="checkbox"/> P <input type="checkbox"/> O	Weight loss		<input type="checkbox"/> P <input type="checkbox"/> O	Psoriasis	
<input type="checkbox"/> P <input type="checkbox"/> O	Frequent Weight Fluctuations		<input type="checkbox"/> P <input type="checkbox"/> O	Acne	
<input type="checkbox"/> P <input type="checkbox"/> O	Bulimia		<input type="checkbox"/> P <input type="checkbox"/> O	Melanoma	
<input type="checkbox"/> P <input type="checkbox"/> O	Anorexia		<input type="checkbox"/> P <input type="checkbox"/> O	Skin Cancer	
<input type="checkbox"/> P <input type="checkbox"/> O	Binge Eating Disorder		<input type="checkbox"/> P <input type="checkbox"/> O	Other_____	
<input type="checkbox"/> P <input type="checkbox"/> O	Night Eating Syndrome		Blood Type <input type="checkbox"/> A <input type="checkbox"/> B <input type="checkbox"/> AB <input type="checkbox"/> O		
<input type="checkbox"/> P <input type="checkbox"/> O	Eating Disorder (non-specific)		<input type="checkbox"/> Rh+ <input type="checkbox"/> unknown		
<input type="checkbox"/> P <input type="checkbox"/> O	Other_____				

Neurological		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Depression	
<input type="checkbox"/> P <input type="checkbox"/> O	Anxiety	
<input type="checkbox"/> P <input type="checkbox"/> O	Bipolar Disorder	
<input type="checkbox"/> P <input type="checkbox"/> O	Schizophrenia	
<input type="checkbox"/> P <input type="checkbox"/> O	Headaches	
<input type="checkbox"/> P <input type="checkbox"/> O	Migraines	
<input type="checkbox"/> P <input type="checkbox"/> O	ADD/ADHD	
<input type="checkbox"/> P <input type="checkbox"/> O	Benign Tremors	

Neurological cont		Date of Onset
<input type="checkbox"/> P <input type="checkbox"/> O	Autism	
<input type="checkbox"/> P <input type="checkbox"/> O	Mild Cognitive Impairment	
<input type="checkbox"/> P <input type="checkbox"/> O	Memory Problems	
<input type="checkbox"/> P <input type="checkbox"/> O	Parkinson's Disease	
<input type="checkbox"/> P <input type="checkbox"/> O	Multiple Sclerosis	
<input type="checkbox"/> P <input type="checkbox"/> O	ALS	
<input type="checkbox"/> P <input type="checkbox"/> O	Seizures	
<input type="checkbox"/> P <input type="checkbox"/> O	Other_____	



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### FAMILY HISTORY

Relative	Age if Living	Age when deceased	Ailments
Father			
Mother			
Siblings			
Paternal grandmother			
Paternal grandfather			
Maternal grandmother			
Maternal grandfather			

Has your relative(s) ever had any of the following?

Condition	Circle One	Which Relative?
alcoholism	<input type="checkbox"/> yes <input type="checkbox"/> no	
allergies/asthma	<input type="checkbox"/> yes <input type="checkbox"/> no	
arthritis	<input type="checkbox"/> yes <input type="checkbox"/> no	
cancer	<input type="checkbox"/> yes <input type="checkbox"/> no	
dementia	<input type="checkbox"/> yes <input type="checkbox"/> no	
diabetes	<input type="checkbox"/> yes <input type="checkbox"/> no	
heart disease	<input type="checkbox"/> yes <input type="checkbox"/> no	
high blood pressure	<input type="checkbox"/> yes <input type="checkbox"/> no	
mental illness	<input type="checkbox"/> yes <input type="checkbox"/> no	
obesity	<input type="checkbox"/> yes <input type="checkbox"/> no	
osteoporosis	<input type="checkbox"/> yes <input type="checkbox"/> no	
stroke	<input type="checkbox"/> yes <input type="checkbox"/> no	
hypo/hyperthyroid	<input type="checkbox"/> yes <input type="checkbox"/> no	

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## LIFESTYLE/PERSONAL HEALTH HISTORY

Roles /Relationship						
Occupation						
Marital status	<input type="checkbox"/> single	<input type="checkbox"/> married	<input type="checkbox"/> partnership	<input type="checkbox"/> gay/lesbian	<input type="checkbox"/> divorced	<input type="checkbox"/> widowed
Children (List name, gender and age) _____ _____						
Are you sexually active?	<input type="checkbox"/> yes <input type="checkbox"/> no	Are you satisfied with your sex life?			<input type="checkbox"/> yes <input type="checkbox"/> no	
Do you or your partner(s) use contraception?				<input type="checkbox"/> yes <input type="checkbox"/> no	What type? _____	
Smoking/Alcohol Intake/Other Substances						
Currently smoking? <input type="checkbox"/> yes <input type="checkbox"/> no    How many packs? _____ How many years? _____						
Attempts to quit?	<input type="checkbox"/> yes <input type="checkbox"/> no	Are you exposed to second hand smoke?			<input type="checkbox"/> yes <input type="checkbox"/> no	
Previous Smoking: How many years? _____ Packs per day? _____						
How many drinks currently per week? 1 drink = 5 ounces wine, 12 ounces beer, 1.5 ounces spirits <input type="checkbox"/> None <input type="checkbox"/> 1-3 <input type="checkbox"/> 4-6 <input type="checkbox"/> 7-10 <input type="checkbox"/> >10 (If none, skip to the next section).						
Previous alcohol intake? <input type="checkbox"/> yes ( <input type="checkbox"/> Mild <input type="checkbox"/> Moderate <input type="checkbox"/> High) <input type="checkbox"/> none						
Have you ever been told you should cut down your alcohol intake? <input type="checkbox"/> yes <input type="checkbox"/> no						
Have you ever thought about getting help to control or stop your drinking? <input type="checkbox"/> yes <input type="checkbox"/> no						
Do you use recreational drugs?			<input type="checkbox"/> yes <input type="checkbox"/> no	Type?		
Exercise						
Current exercise program: List type of activity, number of sessions/week and duration						
Activity	Type	Frequency/Week		Duration in Minutes		
Stretching						
Cardio/Aerobics						
Strength						
Other (yoga, pilates, etc)						
Leisure activities (golf, etc)						
Rate your level of motivation for including exercise in your life? <input type="checkbox"/> Low <input type="checkbox"/> Medium <input type="checkbox"/> High						
List problems that limit activity? _____						
Do you feel unusually fatigued after exercise <input type="checkbox"/> yes <input type="checkbox"/> no If yes, describe: _____ _____						

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## LIFESTYLE/PERSONAL HEALTH HISTORY-CONTINUED

<b>Energy/Sleep/Rest</b>			
Rate your energy level between 1 - 10 (1 = extreme fatigue, 10 = most energy)			
At what time of day is your energy...	the best?		the worst?
How much time do you spend outdoors per week?			
What do you do to relax? List some examples.			
How often do you relax?			
Average number of hours you sleep per night? <input type="checkbox"/> 10 <input type="checkbox"/> 8-10 <input type="checkbox"/> 6-8 <input type="checkbox"/> <6			
Do you have trouble falling to sleep? <input type="checkbox"/> yes <input type="checkbox"/> no		Do you feel rested upon waking? <input type="checkbox"/> yes <input type="checkbox"/> no	
Do you have trouble staying to sleep? <input type="checkbox"/> yes <input type="checkbox"/> no		Do you snore? <input type="checkbox"/> yes <input type="checkbox"/> no	
<b>Stress/Coping</b>			
Rate your stress level between 1 - 10 (1 = least stress, 10 = most stressed)			
What are your biggest stressors? Please list.			
Who is in your support network?			
Do you have a spiritual practice?			
If yes, what is it?			
What behaviors or habits do you engage in regularly to support your health?			
What behaviors or habits do you engage in regularly that are destructive to your health?			
What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health?			



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## DIETARY INTAKE

Describe your daily food/fluid intake		
Breakfast		
Snack		
Lunch		
Snack		
Dinner		
Snack		
How much water do you drink daily?	(1 serving = 8 ounces)	_____
How many sodas, coffees and teas do you drink daily?	(1 serving = 8 ounces)	_____
How many times per week do you eat red meat?	(1 serving = 3-4 ounces)	_____
How many times per week do you eat fish?	(1 serving = 3-4 ounces)	_____
How many times per day do you eat fruit?	(1 serving = 1/2 cup portion)	_____
How many times per day do you eat veggies?	(1 serving = 1/2 cup portion)	_____
Do you eat organic food? <input type="checkbox"/> yes <input type="checkbox"/> no	Do you dine out? <input type="checkbox"/> yes <input type="checkbox"/> no	
Please list any dietary restrictions.		
Are you satisfied with your current diet?	<input type="checkbox"/> yes <input type="checkbox"/> no If no, please explain. _____ _____	
What is your current....	weight?	height?
What is your ideal weight?		

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Intake form, 10

## REVIEW OF SYSTEMS

Y = presently have N = never had P = have had in the past

General	
Cold hands/feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Daytime sleepiness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficulty falling to sleep	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fatigue	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Flushing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heat intolerance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Skin	
Rashes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eczema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Acne	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bruise easily	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hives	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Psoriasis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Athlete's foot	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Dry	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mole color change	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Neurological	
Paralysis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Numbness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tingling	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Loss of balance	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Head   Eyes   Ears   Nose   Throat	
Headaches	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Migraines	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Head injury	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vision problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eye pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Tearing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Eye dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Glaucoma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cataracts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ear pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
ringing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hearing loss	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ear discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Jaw pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Nosebleeds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hay fever	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sinus problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Post nasal drip	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sore tongue	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gum problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Teeth problems	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Canker sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Distorted taste	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hoarseness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swollen glands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Goiter	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Neck pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Respiratory	
Cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Wheezing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chronic cough	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Asthma	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Emphysema	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent Colds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficult breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Pain on breathing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Positive TB test	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Shortness of breath	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
at night	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
on exertion	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
lying down	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Cardiovascular	
Palpitations	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Chest pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heart Disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Low blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Poor circulation	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Leg cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swelling of feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Varicose veins	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hemorrhoids	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold hands	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold feet	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Anemia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

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Gastrointestinal	
Nausea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Vomiting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Diarrhea	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Constipation	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bloating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Heartburn	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Ulcer	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Belching/Gas	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Trouble Swallowing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Change in Thirst	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Blood in Stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Undigested food in stool	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching around rectum	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Liver disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Gallbladder disease	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Daily bowel movements	
is this a change?	<input type="checkbox"/> Y <input type="checkbox"/> N
Have you ever traveled to a third world country?	<input type="checkbox"/> Y <input type="checkbox"/> N

Musculoskeletal	
Joint pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Joint stiffness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Arthritis	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Weakness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle spasms	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Muscle cramps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Broken bones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sciatica	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Endocrine	
10 pounds change in weight	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Sluggish after eating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Generally feet hot	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Generally feel cold	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Low blood sugar	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mental sluggishness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Recently lost or gained weight?	<input type="checkbox"/> Y <input type="checkbox"/> N
Do you wake feeling rested?	<input type="checkbox"/> Y <input type="checkbox"/> N

Immune	
Chronic infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent antibiotics	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent colds	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Cold sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Swollen glands or lymph nodes	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Slow wound healing	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent sore throats	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Shingles	<input type="checkbox"/> Y <input type="checkbox"/> N
Has there every been a sickness that you have never fully recovered from? If yes, explain	
_____	
_____	
_____	



Mental/Emotional	
Abuse	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Anxiety	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Depression	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Difficulty:	
concentrating	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
with judgment	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
with thinking	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
with speech	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
with memory	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mood swings	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Mental illness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Panic attacks	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Phobias	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Prolonged sadness or grief	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
What was the most stressful event in your life?	
_____	
_____	
Is it still affecting you?	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Urinary	
Pain on urination	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Bedwetting	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Increased frequency	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Hesitancy	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Frequent infections	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Inability to hold urine	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Awake to urinate	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Strain to urinate	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Kidney stones	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Intake form, 12

FEMALE ONLY: Female Reproductive Health					
Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Pain during intercourse	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Low sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Itching	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Sores, growths, lumps	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	# of Births	
Vaginal dryness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Odor	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	# of Abortions	
Have you used birth control pills? <input type="checkbox"/> Y <input type="checkbox"/> N For how long? _____				# of Miscarriages	
When was your last pap smear?		Was it normal?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

Premenstrual / Menstrual / Menopause symptoms			
Age of first menses?		Age of last mense (if applicable?)	
How long is your cycle (in days)?		How many days is your menses?	
Describe PMS symptoms (if applicable)			
Describe menstrual symptoms (if applicable)			
Describe menopausal symptoms (if applicable)			

Female Breast Health					
Nipple Discharge	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Tenderness	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Dry skin on nipples	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Breast lump	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Fibrocystic breasts	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Puckering of skin	
Do you perform monthly self breast exams? <input type="checkbox"/> Y <input type="checkbox"/> N				Last Performed	
When was your last breast exam?		Do you have regular mammograms?		<input type="checkbox"/> Yes <input type="checkbox"/> No	

MALE ONLY: Male Reproductive Health					
Hernia	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Testicular pain	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Low sex drive	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Discharge or sores	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Sexual difficulties	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Prostate condition	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P
Testicular mass	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P	Impotence	<input type="checkbox"/> Y <input type="checkbox"/> N <input type="checkbox"/> P		
When was your last prostate exam?					

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

Intake form, 13

PREVENTATIVE TESTS/TESTING			
Test	When	For what reason?	Results
bone density			
CT scan			
colonoscopy			
EKG			
endoscopy			
full physical exam			
MRI			
ultrasound			
x-ray			
<b>VACCINATIONS</b>			
Have you received all your childhood vaccinations?			<input type="checkbox"/> yes <input type="checkbox"/> no
Have you received the vaccination for chicken pox?			<input type="checkbox"/> yes <input type="checkbox"/> no
Have you received any vaccinations for travel?			<input type="checkbox"/> yes <input type="checkbox"/> no

### ENVIRONMENTAL EXPOSURE

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home, at work or when traveling?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide?	<input type="checkbox"/> yes <input type="checkbox"/> no
Are you sensitive to perfume, gasoline or other vapors?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever lived near a refinery or polluted area?	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you ever lived in a home more than 50 years old?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have amalgam dental fillings? How many? _____	<input type="checkbox"/> yes <input type="checkbox"/> no
Have you had any dental root canal procedures?	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you have any surgical implants? (medical or cosmetic)	<input type="checkbox"/> yes <input type="checkbox"/> no
Do you live near power lines?	<input type="checkbox"/> yes <input type="checkbox"/> no

Thank you for taking the time to fill out this form. We look forward to seeing you.

Signature \_\_\_\_\_ Date \_\_\_\_\_