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:	

Are you currently under the care of a specialist of any kind (ie - gastroenterologist, acupuncturist, counselor?		
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:
Name:	Specialty:	Location:

Patient Name:__________________________ DOB:____________ 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? ____

____

Patient Name:__________________________ DOB:____________ Intake form, 3

PAST MEDICAL CONDITIONS

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

	Gastrointestinal	Date of Onset
□ P □ O	Irritable Bowel Disease	
□ P □ O	Inflammatory Bowel Disease	
□ P □ O	Crohn's	
□ P □ O	Ulcerative Colitis	
□ P □ O	Gastritis or Ulcer	
□ P □ O	GERD (reflux)	
□ P □ O	Celiac disease	
□ P □ O	Other______________________	

	Cardiovascular	Date of Onset
□ P □ O	Heart Attack	
□ P □ O	Other Heart Disease	
□ P □ O	Stroke	
□ P □ O	Elevated cholesterol	
□ P □ O	Arrythmia	
□ P □ O	Hypertension	
□ P □ O	Rhuematic Fever	
□ P □ O	Mitral Valve Prolapse	
□ P □ O	Other______________________	

	Cancer	Date of Onset
□ P □ O	Lung cancer	
□ P □ O	Breast cancer	
□ P □ O	Colon cancer	
□ P □ O	Ovarian cancer	
□ P □ O	Prostate cancer	
□ P □ O	Skin cancer	
□ P □ O	Other______________________	

	Genital/Urinary	Date of Onset
□ P □ O	Kidney stones	
□ P □ O	Gout	
□ P □ O	Interstitial Cystitis	
□ P □ O	Frequent Urinary Tract Infections	
□ P □ O	Frequent Yeast Infections	
□ P □ O	Erectile/Sexual Dysfunction	
□ P □ O	Other______________________	

	Musculoskeletal	Date of Onset
□ P □ O	Osteoarthritis	
□ P □ O	Fibromyalgia	
□ P □ O	Chronic pain	
□ P □ O	Other______________________	

	Inflammatory/Immune	Date of Onset
□ P □ O	Chronic Fatigue Syndrome	
□ P □ O	Autoimmune Disease	
□ P □ O	Rheumatoid Arthritis	
□ P □ O	Lupus SLE	
□ P □ O	Immune Deficiency Disease	
□ P □ O	Genital Herpes	
□ P □ O	Severe Immune Disease	
□ P □ O	Frequent Infections	
□ P □ O	Food Allergies	
□ P □ O	Environmental Allergies	
□ P □ O	Multiple Chemical Sensitivities	
□ P □ O	Latex Allergy	
□ P □ O	Other______________________	

Patient Name:_________________________ DOB:___________

PAST MEDICAL CONDITIONS-CONTINUED

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

Metabolic/Endocrine		Date of Onset
☐ P ☐ O	Type 1 Diabetes	
☐ P ☐ O	Type 2 Diabetes	
☐ P ☐ O	Hypoglycemia	
☐ P ☐ O	Metabolic Syndrome	
☐ P ☐ O	Hypothyroidism	
☐ P ☐ O	Hyperthyroidism	
☐ P ☐ O	Endocrine Problems	
☐ P ☐ O	Polycystic Ovarian Syndrome	
☐ P ☐ O	Infertility	
☐ P ☐ O	Weight gain	
☐ P ☐ O	Weight loss	
☐ P ☐ O	Frequent Weight Fluctuations	
☐ P ☐ O	Bulimia	
☐ P ☐ O	Anorexia	
☐ P ☐ O	Binge Eating Disorder	
☐ P ☐ O	Night Eating Syndrome	
☐ P ☐ O	Eating Disorder (non-specific)	
☐ P ☐ O	Other______________________	

Respiratory		Date of Onset
☐ P ☐ O	Asthma	
☐ P ☐ O	Chronic Sinusitis	
☐ P ☐ O	Bronchitis	
☐ P ☐ O	Emphysema	
☐ P ☐ O	Pneumonia	
☐ P ☐ O	Tuberculosis	
☐ P ☐ O	Sleep Apnea	
☐ P ☐ O	Other______________________	

Skin		Date of Onset
☐ P ☐ O	Eczema	
☐ P ☐ O	Psoriasis	
☐ P ☐ O	Acne	
☐ P ☐ O	Melanoma	
☐ P ☐ O	Skin Cancer	
☐ P ☐ O	Other______________________	

Blood Type ☐ A ☐ B ☐ AB ☐ O
☐ Rh+ ☐ unknown

Neurological		Date of Onset
☐ P ☐ O	Depression	
☐ P ☐ O	Anxiety	
☐ P ☐ O	Bipolar Disorder	
☐ P ☐ O	Schizophrenia	
☐ P ☐ O	Headaches	
☐ P ☐ O	Migraines	
☐ P ☐ O	ADD/ADHD	
☐ P ☐ O	Benign Tremors	

Neurological cont		Date of Onset
☐ P ☐ O	Autism	
☐ P ☐ O	Mild Cognitive Impairment	
☐ P ☐ O	Memory Problems	
☐ P ☐ O	Parkinson's Disease	
☐ P ☐ O	Multiple Sclerosis	
☐ P ☐ O	ALS	
☐ P ☐ O	Seizures	
☐ P ☐ O	Other______________________	

MEDICATIONS/SUPPLEMENTS

List all prescription meditations, over the counter medications and supplements.

Medication/Supplement (include brand)	Dose/Frequency	Start Date (month/year)	Reason for taking

Have you ever used any of the following ? (Check all that apply)			
☐ antibiotics more than 2 weeks	☐ antacids	☐ antihistamines	☐ blood thinners
☐ antibiotics more than 2 times/year	☐ diuretics	☐ sleeping pills	☐ steroids
☐ oral contraceptive/hormone therapy	☐ laxatives/stool softener	☐ thyroid medication	☐ stimulants

PAST MEDICAL HISTORY

ALLERGIES - Please list all known allergies to medications, supplements, food, and environment

SURGERIES/HOSPITALIZATIONS

Procedure/Reason	Year

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	☐ yes ☐ no	
allergies/asthma	☐ yes ☐ no	
arthritis	☐ yes ☐ no	
cancer	☐ yes ☐ no	
dementia	☐ yes ☐ no	
diabetes	☐ yes ☐ no	
heart disease	☐ yes ☐ no	
high blood pressure	☐ yes ☐ no	
mental illness	☐ yes ☐ no	
obesity	☐ yes ☐ no	
osteoporosis	☐ yes ☐ no	
stroke	☐ yes ☐ no	
hypo/hyperthyroid	☐ yes ☐ no	

LIFESTYLE/PERSONAL HEALTH HISTORY

Roles /Relationship

Occupation						
Marital status	☐ single	☐ married	☐ partnership	☐ gay/lesbian	☐ divorced	☐ widowed

Children (List name, gender and age) ____

____

Are you sexually active?	☐ yes ☐ no	Are you satisfied with your sex life?	☐ yes ☐ no

Do you or your partner(s) use contraception?	☐ yes ☐ no	What type? ____________________

Smoking/Alcohol Intake/Other Substances

Currently smoking? ☐ yes ☐ no How many packs? _______ How many years? _______

Attempts to quit?	☐ yes ☐ no	Are you exposed to second hand smoke?	☐ yes ☐ 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
☐ None ☐ 1-3 ☐ 4-6 ☐ 7-10 ☐ >10 (*If none, skip to the next section*).

Previous alcohol intake? ☐ yes (☐ Mild ☐ Moderate ☐ High) ☐ none

Have you ever been told you should cut down your alcohol intake? ☐ yes ☐ no

Have you ever thought about getting help to control or stop your drinking? ☐ yes ☐ no

Do you use recreational drugs?	☐ yes ☐ 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? ☐ Low ☐ Medium ☐ High

List problems that limit activity? ____

Do you feel unusually fatigued after exercise ☐ yes ☐ no If yes, describe: ______________________________

____

LIFESTYLE/PERSONAL HEALTH HISTORY-CONTINUED

Energy/Sleep/Rest				
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 to 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? ◻ 10 ◻ 8-10 ◻ 6-8 ◻ <6				
Do you have trouble falling to sleep? ◻ yes ◻ no	Do you feel rested upon waking? ◻ yes ◻ no			
Do you have trouble staying to sleep? ◻ yes ◻ no	Do you snore? ◻ yes ◻ no			
Stress/Coping				
Rate your stress level between 1 -10 (1 = least stress, 10 - most stressed)				
What are you 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				

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? ☐ yes ☐ no	Do you dine out? ☐ yes ☐ no	
Please list any dietary restrictions.		
Are you satisfied with your current diet?	☐ yes ☐ no If no, please explain. ________________________________ ____	
What is your current….	weight?	height?
What is your ideal weight?		

Patient Name:___________________________ DOB:____________

REVIEW OF SYSTEMS

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

General	
Cold hands/feet	☐ Y ☐ N ☐ P
Cold intolerance	☐ Y ☐ N ☐ P
Daytime sleepiness	☐ Y ☐ N ☐ P
Difficulty falling to sleep	☐ Y ☐ N ☐ P
Fatigue	☐ Y ☐ N ☐ P
Fever	☐ Y ☐ N ☐ P
Flushing	☐ Y ☐ N ☐ P
Heat intolerance	☐ Y ☐ N ☐ P

Skin	
Rashes	☐ Y ☐ N ☐ P
Eczema	☐ Y ☐ N ☐ P
Acne	☐ Y ☐ N ☐ P
Bruise easily	☐ Y ☐ N ☐ P
Hives	☐ Y ☐ N ☐ P
Psoriasis	☐ Y ☐ N ☐ P
Athlete's foot	☐ Y ☐ N ☐ P
Itching	☐ Y ☐ N ☐ P
Lumps	☐ Y ☐ N ☐ P
Dry	☐ Y ☐ N ☐ P
Mole color change	☐ Y ☐ N ☐ P

Neurological	
Paralysis	☐ Y ☐ N ☐ P
Numbness	☐ Y ☐ N ☐ P
Tingling	☐ Y ☐ N ☐ P
Muscle weakness	☐ Y ☐ N ☐ P
Loss of memory	☐ Y ☐ N ☐ P
Loss of balance	☐ Y ☐ N ☐ P

Head | Eyes | Ears | Nose | Throat	
Headaches	☐ Y ☐ N ☐ P
Migraines	☐ Y ☐ N ☐ P
Head injury	☐ Y ☐ N ☐ P
Vision problems	☐ Y ☐ N ☐ P
Eye pain	☐ Y ☐ N ☐ P
Tearing	☐ Y ☐ N ☐ P
Eye dryness	☐ Y ☐ N ☐ P
Glaucoma	☐ Y ☐ N ☐ P
Cataracts	☐ Y ☐ N ☐ P
Ear pain	☐ Y ☐ N ☐ P
Ringing	☐ Y ☐ N ☐ P
Hearing loss	☐ Y ☐ N ☐ P
Ear discharge	☐ Y ☐ N ☐ P
Jaw pain	☐ Y ☐ N ☐ P
Nosebleeds	☐ Y ☐ N ☐ P
Stuffiness	☐ Y ☐ N ☐ P
Hay fever	☐ Y ☐ N ☐ P
Sinus problems	☐ Y ☐ N ☐ P
Post nasal drip	☐ Y ☐ N ☐ P
Sore tongue	☐ Y ☐ N ☐ P
Gum problems	☐ Y ☐ N ☐ P
Teeth problems	☐ Y ☐ N ☐ P
Canker sores	☐ Y ☐ N ☐ P
Distorted taste	☐ Y ☐ N ☐ P
Hoaresness	☐ Y ☐ N ☐ P
Lumps	☐ Y ☐ N ☐ P
Swollen glands	☐ Y ☐ N ☐ P
Goiter	☐ Y ☐ N ☐ P
Neck pain	☐ Y ☐ N ☐ P

Respiratory	
Cough	☐ Y ☐ N ☐ P
Wheezing	☐ Y ☐ N ☐ P
Chronic cough	☐ Y ☐ N ☐ P
Asthma	☐ Y ☐ N ☐ P
Emphysema	☐ Y ☐ N ☐ P
Frequent Colds	☐ Y ☐ N ☐ P
Difficult breathing	☐ Y ☐ N ☐ P
Pain on breathing	☐ Y ☐ N ☐ P
Positive TB test	☐ Y ☐ N ☐ P
Shortness of breath	☐ Y ☐ N ☐ P
at night	☐ Y ☐ N ☐ P
on exertion	☐ Y ☐ N ☐ P
lying down	☐ Y ☐ N ☐ P

Cardiovascular	
Palpitations	☐ Y ☐ N ☐ P
Chest pain	☐ Y ☐ N ☐ P
Heart Disease	☐ Y ☐ N ☐ P
High blood pressure	☐ Y ☐ N ☐ P
Low blood pressure	☐ Y ☐ N ☐ P
Poor circulation	☐ Y ☐ N ☐ P
Leg cramps	☐ Y ☐ N ☐ P
Swelling of feet	☐ Y ☐ N ☐ P
Varicose veins	☐ Y ☐ N ☐ P
Hemorrhoids	☐ Y ☐ N ☐ P
Cold hands	☐ Y ☐ N ☐ P
Cold feet	☐ Y ☐ N ☐ P
Anemia	☐ Y ☐ N ☐ P

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

Musculoskeletal	
Joint pain	◻ Y ◻ N ◻ P
Joint stiffness	◻ Y ◻ N ◻ P
Arthritis	◻ Y ◻ N ◻ P
Weakness	◻ Y ◻ N ◻ P
Muscle spasms	◻ Y ◻ N ◻ P
Muscle cramps	◻ Y ◻ N ◻ P
Broken bones	◻ Y ◻ N ◻ P
Sciatica	◻ Y ◻ N ◻ P

Endocrine	
10 pounds change in weight	◻ Y ◻ N ◻ P
Sluggish after eating	◻ Y ◻ N ◻ P
Generally feet hot	◻ Y ◻ N ◻ P
Generally feel cold	◻ Y ◻ N ◻ P
Low blood sugar	◻ Y ◻ N ◻ P
Mental sluggishness	◻ Y ◻ N ◻ P
Recently lost or gained weight?	◻ Y ◻ N
Do you wake feeling rested?	◻ Y ◻ N

Immune	
Chronic infections	◻ Y ◻ N ◻ P
Frequent antibiotics	◻ Y ◻ N ◻ P
Frequent colds	◻ Y ◻ N ◻ P
Cold sores	◻ Y ◻ N ◻ P
Swollen glands or lymph nodes	◻ Y ◻ N ◻ P
Slow wound healing	◻ Y ◻ N ◻ P
Frequent sore throats	◻ Y ◻ N ◻ P
Shingles	◻ Y ◻ N
Has there every been a sickness that you have never fully recovered from? If yes, explain ____________________ ____________________ ____________________	

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

Urinary	
Pain on urination	◻ Y ◻ N ◻ P
Bedwetting	◻ Y ◻ N ◻ P
Increased frequency	◻ Y ◻ N ◻ P
Hesitancy	◻ Y ◻ N ◻ P
Frequent infections	◻ Y ◻ N ◻ P
Inability to hold urine	◻ Y ◻ N ◻ P
Awake to urinate	◻ Y ◻ N ◻ P
Strain to urinate	◻ Y ◻ N ◻ P
Kidney stones	◻ Y ◻ N ◻ P

Patient Name:__________________________ DOB:____________

FEMALE ONLY: Female Reproductive Health					
Discharge	☐ Y ☐ N ☐ P	Pain during intercourse	☐ Y ☐ N ☐ P	Low sex drive	☐ Y ☐ N ☐ P
Itching	☐ Y ☐ N ☐ P	Sores, growths, lumps	☐ Y ☐ N ☐ P	# of Births	
Vaginal dryness	☐ Y ☐ N ☐ P	Odor	☐ Y ☐ N ☐ P	# of Abortions	
Have you used birth control pills? ☐ Y ☐ N For how long? ______				# of Miscarriages	
When was your last pap smear?			Was it normal?	☐ Yes ☐ 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	☐ Y ☐ N ☐ P	Tenderness	☐ Y ☐ N ☐ P	Dry skin on nipples	☐ Y ☐ N ☐ P
Breast lump	☐ Y ☐ N ☐ P	Fibrocystic breasts	☐ Y ☐ N ☐ P	Puckering of skin	
Do you perform monthly self breast exams? ☐ Y ☐ N				Last Performed	
When was your last breast exam?			Do you have regular mammograms?		☐ Yes ☐ No

MALE ONLY: Male Reproductive Health					
Hernia	☐ Y ☐ N ☐ P	Testicular pain	☐ Y ☐ N ☐ P	Low sex drive	☐ Y ☐ N ☐ P
Discharge or sores	☐ Y ☐ N ☐ P	Sexual difficulties	☐ Y ☐ N ☐ P	Prostate condition	☐ Y ☐ N ☐ P
Testicular mass	☐ Y ☐ N ☐ P	Impotence	☐ Y ☐ N ☐ P		
When was your last prostate exam?					

PREVENTATIVE TESTS/TESTING			
Test	When	For what reason?	Results
bone density			
CT scan			
colonoscopy			
EKG			
endoscopy			
full physical exam			
MRI			
ultrasound			
x-ray			

VACCINATIONS	
Have you received all your childhood vaccinations?	☐ yes ☐ no
Have you received the vaccination for chicken pox?	☐ yes ☐ no
Have you received any vaccinations for travel?	☐ yes ☐ 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?	☐ yes ☐ no
Have you ever experienced health problems after putting down new carpets, painting, doing renovations or having your lawn sprayed with herbicide?	☐ yes ☐ no
Are you sensitive to perfume, gasoline or other vapors?	☐ yes ☐ no
Have you ever lived near a refinery or polluted area?	☐ yes ☐ no
Have you ever lived in a home more than 50 years old?	☐ yes ☐ no
Do you have amalgam dental fillings? How many? _______	☐ yes ☐ no
Have you had any dental root canal procedures?	☐ yes ☐ no
Do you have any surgical implants? (medical or cosmetic)	☐ yes ☐ no
Do you live near power lines?	☐ yes ☐ no

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

Signature ____ Date ________________