NEW PATIENT INTAKE FORM

Name_____Date_____
Date of Birth _____ Occupation _____
Email Address_____
Address_____
Home Phone Number_____ Cell Phone Number _____
Emergency Contact and Phone Number _____
Major Complaints

_____
_____
_____
_____
_____
_____

How long have you had this
condition?_____
What makes it better?_____
What makes it worse?_____
Medications you are currently taking

_____
_____
_____

List Surgeries/Operations you have had

_____
_____
_____

Medical History (Do you have or ever had): ☐ Arthritis ☐ Asthma ☐ Anemia
☐ Heart trouble ☐ Cancer ☐ High Blood Pressure
☐ Kidney or Bladder Trouble

Family History (Has any member had any of the above)? ___Yes ___No If yes, which member and what did they have?

_____

Energy Level: _____High (Time of Day)_____ _____Low (Time of Day)_____
Stress ☐ None ☐ Moderate ☐ High
Sweating: ☐ Night Sweats ☐ Rarely Sweats ☐ Excessive

Circulation: Feelings of ☐ Hot ☐ Cold
What area?_____
☐ Bleeds Easily ☐ Cold Limbs
Skin: ☐ Dry ☐ Itchy ☐ Acne ☐ Hair loss/thinning
☐ Bruises easily
Other_____
Sleep Problems: ☐ Trouble falling asleep ☐ Trouble Staying Asleep
☐ Restful ☐ Excessive Dreaming
Other_____
Head: ☐ Headaches (What area)?_____ ☐ Dizziness
☐ Memory Loss ☐ Loss of Balance
Other_____
Ears: ☐ Poor Hearing ☐ Ringing in Ears
Eyes: ☐ Dry Eyes ☐ Blurry Vision
Nose: ☐ Frequent Nose Bleeds ☐ Sinus Trouble ☐ Frequent Colds
Throat: ☐ Sore Throat ☐ Jaw Problems ☐ Teeth Problems

Chest: ☐ Hard to Breathe ☐ Wheezing ☐ Shortness of Breath
☐ Palpitations ☐ Coughing Phlegm ☐ Persistent Cough
☐ Pain/Pressure in Chest
Blood Pressure: ☐ High ☐ Low
Bowels: ☐ Diarrhea ☐ Constipation ☐ Bloody Stools ☐ Hemorrhoids
☐ Gas ☐ Number of Bowel Movements per Day
Urine: ☐ Frequent Urination ☐ Burning Urination ☐ Water Retention
☐ Incontinence ☐ Night time
Other_____
Musculoskeletal: Pain in: ☐ Neck ☐ Shoulder ☐ Between Shoulders
☐ Arms/Hands ☐ Hip ☐ Knee ☐ Fingers ☐ Upper Back
☐ Mid Back ☐ Lower Back ☐ Leg Cramps ☐ Painful Joints
☐ Tingling in Feet ☐ Muscle Spasms/Cramps
Other_____
Neurological: ☐ Depressed ☐ Easily Angered ☐ Frequent Crying
☐ Anxiety ☐ Mood Swings ☐ Poor Concentration ☐ Tremors
☐ Seizures ☐ Numbness/Tingling
Females: ☐ Pregnant? ☐ First Day of Last Monthly Period
Menstrual Cycle: ☐ Irregular ☐ Clotting ☐ Heavy Bleeding ☐ Light/Scanty
☐ Mood Changes ☐ Low or no Sex Drive ☐ Painful Breasts ☐ Hot Flashes

Discharges: ☐ Yellow ☐ Thick ☐ White ☐ Itching
Males: ☐ Low Sex Drive ☐ Impotence ☐ Premature ejaculation
Appetite: ☐ Excessive appetite ☐ Poor Appetite ☐ Excessive thirst
Digestion: ☐ Stomach Gas ☐ Heartburn ☐ Belching
☐ Stomach pain ☐ Bitter taste in mouth ☐ Abdominal bloating
Food allergies?
If yes, to what?_____

medication currently
Over the counte
Vitamin + Supplements