Health Intake Form

Basic Information

Today's Date: _____

Your Name: _____

Date of birth: _____ Age: _____ Biological Sex: Male Female

Height: _____ Weight: _____ Blood Type: _____ BMI: _____

Address: _____

Phone: Home: _____ Cell: _____

Email: _____

Person to notify in case of emergency: _____

Cell: _____

Who can we thank for referring you? _____

Has any other family member already been a patient at the clinic? Y or N

What goals do you have for your visit today?

- _____
- _____

History & Intake

What are your major health concerns in order of importance?

1. _____ 3. _____
2. _____ 4. _____

How did these conditions develop? Are there traumatic events, medications, etc that you can identify as having caused or clearly aggravated your health problems. What happened in your life around this time?

_____

_____

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Medications (list all prescriptions with dosages):

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

Natural: Vitamins, Supplements, herbs with dosages:

1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

What other health care practitioners are you currently seeing?

1. _____ 3. _____
2. _____ 4. _____

Are you allergic to any drugs, foods, chemicals, animals, environmental substances?

What/what happens?_____

Significant Life Events:

- Major traumas, emotional loss, accidents:

  _____

- Hospitalizations:

  _____

- Significant childhood illnesses:

  _____

- Surgeries:

  _____

- Dental issues or trauma:

  _____

- Recent Vaccinations (in last 3 years):

  _____

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Family/Past Medical History:

Home Life: Alone: _____ Spouse/Partner: _____ Parent: _____

Do you have any children? Yes No How many? _____

Your Mom's Pregnancy/Labor: Any health stressors & complications?

_____

C section? Y or N Umbilical Cord issues? Y or N Antibiotics? Y or N

Breast Fed? Y or N Formula fed? Y or N Did you have colic? Y or N

What foods do you grow up on? _____

What significant childhood illnesses have you had?

- Rashes/cradle cap: Y or N Constipation: Y or N Colic: Y or N
- Mononucleosis: Y or N Strep Throat: Y or N Asthma: Y or N

Significant Family/Genetic History: *(list age if deceased)—-Has any Blood Relative had any of the following: Heart Disease, Cancer, Diabetes, Kidney disease, Autoimmune Disease, or Lyme Disease?*

Your Siblings: _____

Mother: _____

Father: _____

Grandparents: _____

LIFESTYLE:

Mold or water damaged building at home, office, school? Y or N

Do you drink alcohol? Y or N How many days per week? _____

Do you use tobacco or have you in the past? Y or N

Have you ever been exposed to or use currently:

- Air fresheners, scented laundry detergent, dryer sheets? Y or N
- Chemicals, Mold, water damaged buildings? Y or N

Do you react to cosmetics, perfumes, colognes, scents, mold? Y or N

Do you exercise? Y or N Please explain: _____

Do you make time for rest, relaxation or meditation? Y or N

Do you feel stressed most days? Y or N

What are your interests or hobbies? _____

DIET:

How much water (in ounces) do you drink daily? _____

Are you satisfied with your diet as it is now? Y or N

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Do you follow any particular diet or restrictions? Y or N

Please explain: _____

List any foods you crave? _____

How many meals do you generally eat each day? 1 2 3 4 5 6

Do you react to any foods? Y or N What is reaction? _____

What do you eat for?

- Breakfast: _____
- Lunch: _____
- Dinner: _____
- Late night: _____

Do you consume?:

- Coffee or Caffeinated teas: Y or N Sugar or Artificial sweeteners: Y or N
- Processed foods: Y or N Margarine, Seed oils: Y or N

SLEEP:

Do you have trouble falling asleep? Y or N

Do you wake at night and can't fall back to sleep? Y or N

Do you wake feeling refreshed? Y or N Do you have recurring dreams? Y or N

PERSONAL/WELLBEING:

If you are working, are you happy in your job or career? Y or N

Is your present sex life satisfactory? Y or N

What personal goals do you have? _____

What makes you happy? _____

What are you grateful for? _____

What is your individual & unique purpose in this life? _____

What would you like to change most about your life? _____

What behaviors, habits, or thoughts would you like to eliminate? _____

GENERAL/REVIEW OF SYSTEMS:	**PAST**	**CURRENTLY**
Skin:		
Jock itch, athletes food, yeast infections, rashes?	_____	_____
Endocrine:		
Unexplained weight loss/gain	_____	_____
Cold hands or feet	_____	_____

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Head:

Dizziness _____ _____
Severe headaches or migraines _____ _____
Seizures, convulsions, epilepsy _____ _____

Eyes:

Poor eyesight _____ _____
Light hurts eyes _____ _____
Eye dryness _____ _____
Glaucoma _____ _____
Macular degeneration _____ _____
Catarracts _____ _____

Ears:

Itching Ears _____ _____
Hearing loss or ear ringing _____ _____
Sensitivity to noise _____ _____

Nose:

Chronic sinus infection, congestion _____ _____
Nasal polyps _____ _____
Loss of smell or taste _____ _____

Mouth:

Sore mouth or tongue _____ _____
Swallowing difficulties _____ _____
Bleeding gums _____ _____
Dental/Teeth issues _____ _____
Grinding at night or Jaw pain _____ _____
Chronic sore throat _____ _____
Swollen tonsils/glands _____ _____

Neck:

Injuries or Pain _____ _____

Lungs/Respiratory:

Bronchitis or Pneumonia _____ _____
Shortness of breath or asthma _____ _____
Daily cough or allergies _____ _____
Sigh frequently _____ _____

Cardiovascular/Circulation:

Chest pain or tightness _____ _____
Stroke or Heart attack _____ _____

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Heart palpitations _____ _____
Heaviness in arms/legs _____ _____

Leg vein problems _____ _____
Numbness/tingling in extremities _____ _____

Ankle or abdominal swelling _____ _____

Gastrointestinal:
Frequency of bowel movements on daily basis: 1 2 3 4 or more

Constipation or Diarrhea _____ _____
Alternating constipation & diarrhea _____ _____

Heartburn or Nausea _____ _____

Bad breath (halitosis) _____ _____

Abdominal bloat/distension _____ _____

Distress from fat or greasy foods _____ _____

Hemorrhoids _____ _____
Blood in stools _____ _____

Change in Appetite or Bowel movement _____ _____
Excessive lower bowel gas _____ _____

Irritable if meals skipped _____ _____

Fatigue relieved by eating _____ _____

Urinary tract:
Frequent urination _____ _____

Night urination _____ _____
Difficulty holding urine _____ _____

Chronic infections _____ _____

Strong odor to urine _____ _____

Male Reproductive:
Prostate problems _____ _____
Infertility _____ _____

Female Reproductive:
Lumps in breast(s) _____ _____
Pelvic pain _____ _____

Vaginal itching/burning _____ _____
Yeast infections (frequent) _____ _____

Endometriosis _____ _____

Painful sex _____ _____
Lack of sexual desire _____ _____
Menstruation excessive _____ _____
Menstruation absent _____ _____
Bleed/spot between periods _____ _____

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Infertility _____ _____
Hot flashes, night sweats, and/or vaginal dryness _____ _____
Fibroids/cysts _____ _____
Have you ever used birth control pills? _____ _____
Age of first menstruation _____
Periods occur every _____ days
pregnancies: ____ # births _____ # miscarriages or abortions _____

PMS symptoms:

Mood changes: Anxiety, depression, anger _____ _____
Headache _____ _____
Cravings or Increased appetite _____ _____
Pain or inflammation increases _____ _____

Thyroid:

Difficulty losing weight _____ _____
Constipation _____ _____
Easily fatigued _____ _____
Dry or scaly skin _____ _____
Chilly/sensitive to cold or low body temperature _____ _____
Hair loss, hair coarse _____ _____
Numbness or Headache upon waking _____ _____

Adrenals:

Easily stressed _____ _____
Chronic fatigue _____ _____
Dizziness on standing _____ _____
Tired in afternoon _____ _____
Hot flashes _____ _____
Craves salt _____ _____

Neurological:

Loss of balance/fainting _____ _____
Dizziness regularly _____ _____
Tremor (shaking, trembling) _____ _____
Blurred/double vision _____ _____
Memory loss _____ _____

Musculoskeletal:

Joint pain/stiffness _____ _____

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Muscle cramps or stiffness _____ _____
Neuropathy or Sciatica _____ _____
Scoliosis _____ _____

Emotional:

Anxiety or Excessive worry _____ _____
Depression, despair _____ _____
Suicidal thoughts or attempts _____ _____
Loneliness/Feeling alone _____ _____
Mood swings _____ _____
Fears/phobias _____ _____
Mental confusion, decreased concentration _____ _____
Obsessive thoughts _____ _____
Self critical, shame, guilt feelings _____ _____
Lack self-confidence _____ _____
Post traumatic stress syndrome _____ _____
Anger feelings _____ _____
Claustrophobia _____ _____
Emotional eating _____ _____