

Initial Visit: Patient Intake

Name		Home Phone	Cell Phone
Street Address		Email Address	
City		Emergency Contact Name:	
State	Zip	Phone Number(s): _____	
Date of Birth	Occupation / Employer	Relationship: _____	
Physician Phone Number		Referred By	
Age	Height	Weight	Gender
Main Problem and when it began			
Other Concurrent Therapies:			

Health Insurance Information

Insurance Co. Name	Insurance Co. Phone	Insured SS#
Insurance Co. Address	Insurance Type: <input type="checkbox"/> HMO <input type="checkbox"/> PPO <input type="checkbox"/> EPO <input type="checkbox"/> POS	
Insurance Co. City, State, Zip	<input type="checkbox"/> Auto Insurance <input type="checkbox"/> Worker's Comp.	

Family History of Illness

Place a check in the box if you or any family members have had the following illnesses. If you have had the illness yourself, please indicate the date(s) when your illness occurred.

Disease	Yourself	Father	Mother	Sibling	Grandparent
Cancer					
Diabetes; Type?					
High blood pressure					
Heart disease					
Hepatitis B and/or C					
Asthma					
Thyroid disorders					
Seizures					
Rheumatic fever					
HIV / AIDS					

Personal Medical History: Complete the information requested below

Surgeries that you have had; When?	
Significant accidents/trauma (car, falls); When?	
Occupational Stresses (chemical, physical, psychological stresses)	
Exercise (# times a week, type, how long)	

Daily Diet: Please indicate your average/normal meal for each of the following

Morning	Afternoon	Evening

Medications, Herbals, and Nutraceuticals (List those that you have taken in the last two months)

It is essential to disclose all supplements & medicines, both prescription & over the counter which you are taking

Allergies: List all allergies to drugs, chemicals, foods, etc.

Habits: Please indicate how often you consume/use the following (i.e. 1 pack/day, 3 cups/day. Twice a week)

- | | | |
|-------------------------------------|---------------------------------|--|
| <input type="checkbox"/> Cigarettes | <input type="checkbox"/> Cola | <input type="checkbox"/> Tea; Type: _____ |
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Coffee | <input type="checkbox"/> Recreational drugs: _____ |

Please check all that apply:

Appetite & thirst	Temperature	Sleep	Perspiration	Musculoskeletal
<input type="checkbox"/> Lack of appetite <input type="checkbox"/> Insatiable appetite <input type="checkbox"/> Change in appetite <input type="checkbox"/> Cravings <input type="checkbox"/> Change in thirst; Prefer cold drinks <input type="checkbox"/> Strong thirst; Prefer hot drinks	<input type="checkbox"/> Cold hands <input type="checkbox"/> Cold feet <input type="checkbox"/> Cold back <input type="checkbox"/> Cold abdomen <input type="checkbox"/> Chills <input type="checkbox"/> Fevers <input type="checkbox"/> Warm hands <input type="checkbox"/> Warm feet	<input type="checkbox"/> Fatigue <input type="checkbox"/> Restless sleep <input type="checkbox"/> Sleep soundly <input type="checkbox"/> Insomnia <input type="checkbox"/> Wakes often <input type="checkbox"/> Difficulty falling asleep <input type="checkbox"/> Difficulty waking <input type="checkbox"/> Dream disturbed sleep	<input type="checkbox"/> Sweat easily <input type="checkbox"/> Sweaty hands <input type="checkbox"/> Sweaty feet <input type="checkbox"/> Cold sweats <input type="checkbox"/> Night sweats <input type="checkbox"/> Day sweats	<input type="checkbox"/> Arthritis <input type="checkbox"/> Bursitis <input type="checkbox"/> Osteoporosis <input type="checkbox"/> Parkinson's <input type="checkbox"/> Tremors <input type="checkbox"/> Herniated disks <input type="checkbox"/> Fractures; Where? _____
Head	Eyes	Ears	Nose	Mouth & Throat
<input type="checkbox"/> Concussions <input type="checkbox"/> Facial pain <input type="checkbox"/> Vertigo <input type="checkbox"/> Migraines <input type="checkbox"/> Headaches (When & where) _____ _____ <input type="checkbox"/> Other head or neck problems? _____ _____	<input type="checkbox"/> Glasses <input type="checkbox"/> Eye pain <input type="checkbox"/> Cataracts <input type="checkbox"/> Glaucoma <input type="checkbox"/> Night blindness <input type="checkbox"/> Red eyes <input type="checkbox"/> Blurry vision <input type="checkbox"/> Double vision <input type="checkbox"/> Tunnel vision (see center of field) <input type="checkbox"/> Flashes of light/specks in vision <input type="checkbox"/> Dry eyes	<input type="checkbox"/> Ringing in ears <input type="checkbox"/> Earaches <input type="checkbox"/> Ear infections <input type="checkbox"/> Hard of hearing <input type="checkbox"/> Hearing aid	<input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nasal congestion <input type="checkbox"/> Hay fever/allergies <input type="checkbox"/> Sinus problems <input type="checkbox"/> Nasal polyps <input type="checkbox"/> Trouble breathing through nose	<input type="checkbox"/> Excessive saliva <input type="checkbox"/> Dry mouth <input type="checkbox"/> Gum problems <input type="checkbox"/> Bad breath <input type="checkbox"/> Grinding teeth <input type="checkbox"/> Teeth problems <input type="checkbox"/> Jaw clicks <input type="checkbox"/> Lip sores <input type="checkbox"/> Tongue sores <input type="checkbox"/> Dry throat <input type="checkbox"/> Recurrent sore throats <input type="checkbox"/> Feeling of fullness in throat

Please check all that apply:

Neuro-psychological		
<input type="checkbox"/> Traumatic brain injury	<input type="checkbox"/> ADD, ADHD	<input type="checkbox"/> Epilepsy
<input type="checkbox"/> Concussion	<input type="checkbox"/> Schizophrenia	<input type="checkbox"/> Lyme's disease
<input type="checkbox"/> Poor memory	<input type="checkbox"/> Bipolar	<input type="checkbox"/> Easily stressed
<input type="checkbox"/> Autism	<input type="checkbox"/> Seasonal affective disorder	<input type="checkbox"/> Anxiety
<input type="checkbox"/> Obsessive compulsive disorder	<input type="checkbox"/> Chemical dependency	<input type="checkbox"/> Irritability
<input type="checkbox"/> Sensory processing disorder	<input type="checkbox"/> Post-traumatic stress syndrome	<input type="checkbox"/> Depression
<input type="checkbox"/> Difficulty focusing	<input type="checkbox"/> Numbness	<input type="checkbox"/> Considered/attempted suicide
Respiratory		Cardiovascular
<input type="checkbox"/> Hay fever/allergies	<input type="checkbox"/> Asthma	<input type="checkbox"/> Pacemaker
<input type="checkbox"/> Coughs	<input type="checkbox"/> Chronic bronchitis	<input type="checkbox"/> Chest pain
<input type="checkbox"/> Dry cough	<input type="checkbox"/> Emphysema	<input type="checkbox"/> Rib pain
<input type="checkbox"/> Cough with blood	<input type="checkbox"/> Pneumonia	<input type="checkbox"/> High blood pressure
<input type="checkbox"/> Cough with phlegm	<input type="checkbox"/> Shortness of breath	<input type="checkbox"/> Low blood pressure
<input type="checkbox"/> Phlegm color: _____	<input type="checkbox"/> Difficulty breathing	<input type="checkbox"/> Fainting
<input type="checkbox"/> Other lung problems: _____	<input type="checkbox"/> Difficulty breathing on exertion	<input type="checkbox"/> Palpitations/irregular beat
		<input type="checkbox"/> Heart attack
		<input type="checkbox"/> Congestive heart failure
		<input type="checkbox"/> Blood clots
		<input type="checkbox"/> Anemia
		<input type="checkbox"/> Phlebitis
		<input type="checkbox"/> Edema
		<input type="checkbox"/> Swollen hands/feet
		<input type="checkbox"/> Swollen lymph nodes
		<input type="checkbox"/> Other information: _____

Skin and Hair		Gastrointestinal System
<input type="checkbox"/> Rashes	<u>Change in texture or appearance of:</u>	<input type="checkbox"/> Heartburn regularly
<input type="checkbox"/> Hives		<input type="checkbox"/> Heartburn at night
<input type="checkbox"/> Itching	<input type="checkbox"/> Nails	<input type="checkbox"/> Belching
<input type="checkbox"/> Easy bruising	<input type="checkbox"/> Hair	<input type="checkbox"/> Indigestion regularly
<input type="checkbox"/> Pimples/acne	<input type="checkbox"/> Skin	<input type="checkbox"/> Problems with certain foods? Which foods? _____
<input type="checkbox"/> Eczema	<input type="checkbox"/> Mole/wart(s)	_____
<input type="checkbox"/> Psoriasis		<input type="checkbox"/> Gas
<input type="checkbox"/> Ulceration		<input type="checkbox"/> Rectal pain
<input type="checkbox"/> Slow healing sores		<input type="checkbox"/> Hemorrhoids
<input type="checkbox"/> Fungal infections		<input type="checkbox"/> Vomiting
<input type="checkbox"/> Dandruff		<input type="checkbox"/> Nausea
<input type="checkbox"/> Loss of hair		<input type="checkbox"/> Sensitive abdomen
<input type="checkbox"/> Lumps		<input type="checkbox"/> Pain or cramps
		<input type="checkbox"/> Distended feeling? Where? <input type="checkbox"/> Side rib area <input type="checkbox"/> Abdomen area
		<input type="checkbox"/> Diarrhea
		<input type="checkbox"/> Constipation
		<input type="checkbox"/> Regular laxative use
		<input type="checkbox"/> Recent change in bowel habits?
		<u>Bowel Movements</u>
		Loose stools: _____
		Frequency: _____
		Color (black?): _____
		Blood in stools: _____
		Texture/formed: _____
Genitourinary		
<input type="checkbox"/> Pain on urination	<input type="checkbox"/> Frequent urinary tract infections	<input type="checkbox"/> Prostate enlargement
<input type="checkbox"/> Unable to hold urine	<input type="checkbox"/> Kidney stones	<input type="checkbox"/> Impotency
<input type="checkbox"/> Frequent urination	<input type="checkbox"/> Wake up at night to urinate; How often: ___/night; Time: _____	<input type="checkbox"/> Masses, change in testicles
<input type="checkbox"/> Difficulty urinating	<input type="checkbox"/> Bedwetting	<input type="checkbox"/> Sexually transmitted disease
<input type="checkbox"/> Urgency to urinate	<input type="checkbox"/> Genital warts (HPV)	<input type="checkbox"/> Increased libido
<input type="checkbox"/> Blood in urine		<input type="checkbox"/> Decreased libido
Pregnancy & Gynecology		
Are you currently pregnant or may be pregnant? <input type="checkbox"/> Yes <input type="checkbox"/> No		
Age at first menses: _____	<input type="checkbox"/> Breast lumps	<input type="checkbox"/> Pregnancies; How many: _____; Number births: _____
Length of cycle (day 1 to day 1): _____	<input type="checkbox"/> Menopause; Age: _____	<input type="checkbox"/> Miscarriages
Duration of flow: _____	<input type="checkbox"/> Discharge from nipple	<input type="checkbox"/> Premature births
Date last period began: _____	<input type="checkbox"/> Vaginal dryness	<input type="checkbox"/> Infertility
<input type="checkbox"/> Irregular periods	<input type="checkbox"/> Vaginal sores	<input type="checkbox"/> Birth control; Type of birth control: _____
<input type="checkbox"/> Heavy flow	<input type="checkbox"/> Vaginal discharge; Describe the vaginal discharge: _____	<input type="checkbox"/> Date of last PAP: _____
<input type="checkbox"/> Very painful periods	<input type="checkbox"/> Vaginal odor	
<input type="checkbox"/> Skipped periods		
<input type="checkbox"/> Clots in flow		

Please check all that apply:

Pain & Stiffness		
<input type="checkbox"/> Neck pain	<input type="checkbox"/> Knee pain	<input type="checkbox"/> Pain in fingers
<input type="checkbox"/> Neck stiffness	<input type="checkbox"/> Elbow pain	<input type="checkbox"/> Other: _____
<input type="checkbox"/> Back pain	<input type="checkbox"/> Hip pain	_____
<input type="checkbox"/> Shoulder pain	<input type="checkbox"/> Limited range of motion	

On the diagram below, please indicate the areas in which you commonly feel pain.
You may circle the area and/or color it in for pain.

