Patient Intake Form

Name:		**Phone Home:**	**Work:**
Address:		**Age: Ht: Wt.**	
City:		**Birthdate:**	**Sex:**
State:	**Zip:**	**Occupation:**	
Email:		**Social Security #**	
Physician:			
Main Problem:			**Onset:**
Other Concurrent Therapies:			
Referred By:			

Past Medical History (include date):

Significant Illnesses:_____Cancer_____Diabetes_____Heart Disease_____
High Blood Pressure_____Rheumatic Fever_____Thyroid Disease_____
Seizures_____Other_____

Surgeries:____
Significant Trauma: (auto accidents, falls, etc.)___________________________
Birth History: (prolonged labor, forceps delivery, etc.)____________________
Allergies: (drugs, chemicals, foods)____________________________________
Medicines taken within last two months (include vitamins, over-the-counter drugs, herbs, etc.)____
Occupational Stresses (Chemical, physical, psychological, etc.)____________
____
Exercise:____
Comments:____

Average daily diet:

Morning:__________________Afternoon:_______________Eve:_____________
____
____

Habits:

Cigarettes:_____Coffee_____Tea_____Cola_____Alcohol_____Drugs_____
Sugar_____Salt_____Other____

Family Medical History

Diabetes_____Cancer_____High Blood Pressure_____Heart Disease_______
Stroke_____Seizures_____Asthma_____Allergies_____Alcoholism________
Other:____

Notes:____
____
____

General

_____Poor Appetite _____Heavy Appetite _____Poor Sleep _____Heavy Sleep
_____Insomnia _____Fatigue _____Tremors _____Vertigo
_____Cold Hands _____Cold Feet _____Cold Back _____Cold Abdomen
_____Fevers _____Chills _____Night Sweats _____Sweat Easily
_____Poor Coordination _____Localized Weakness _____Cravings ____AppetiteChange
Sudden energy drop at_____(time)_____PeculiarTastes/smells_________________________________
Strong thirst (cold/hot drinks)_____ ____Bleed or Bruise Easily(where)___________________
____
____

Skin and Hair

_____Rashes _____Ulcerations _____Hives _____Itching
_____Eczema _____Pimples _____Dandruff _____Loss of Hair
_____Change hair/skin _____Purpura
Other skin problems:____
____

Head, Eyes, Ears, Nose and Throat

_____Dizziness _____Concussions _____Migraines _____Glasses
_____Eye Strain _____Eye Pain _____Poor Vision _____Night Blindness
_____Ringing in Ears _____Poor Hearing _____Nose Bleeds _____Earaches
_____Mucus _____Dry Throat _____Dry Mouth _____Copius Saliva
_____Teeth Problems _____Jaw clicks _____Grinding Teeth _____Facial Pain
_____Gum Problems _____Spots in eyes _____Recurrent Sore Throats_____/month
Other head or neck problems:____
____
____

Cardiovascular

_____High Blood Pressure_____Low Blood Pressure _____Chest Pain ____Irreg. Heart Beat
_____Dizziness _____Fainting _____Cold hands/feet ___Swollen hand/feet
_____Blood clots _____Phlebitis ___Problem breathing____Other_________
____
____

Respiratory

_____Cough _____Coughing Blood _____Asthma _____Bronchitis
_____Pneumonia _____Difficulty Breathing when lying down _____Phlegm/color
Other:____
____

Gastrointestinal

_____Nausea _____Vomiting _____Diarrhea ___Bowel Movement
_____Gas _____Belching _____Black Stools ________Frequency
_____Bad Breath _____Rectal Pain _____Hemorrhoids ________Color
_____Constipation _____Bloody stools __Sensitive Abdomen ________Odor
_____Pain or Cramps _____Laxatives x per week/type______________ ______Texture/Form
Other:____
____

Genito-Urinary

_____Pain on urination _____Frequent urination _____Blood in urine __Urgency to Urinate
_____Unable to hold urine_____Kidney Stones ___Venereal disease _____Impotency
_____Wake up to urinate _____How often_____/night; time:_____________________________
____
____

Pregnancy and Gynecology

_____Number Pregnancies_____Number births _____Premature births_____Miscarriages
_____Age at 1st menstral _____Period (days) _____Duration _____Irreg. Periods
_____Flow light/heavy _____Clots _____Last PAP _____Last menstral
_____Vaginal Discharge _____Vaginal Sores _____Breast lumps _____Menopause
_____Birth Control type and duration:____
Changes in body/psyche prior to menstruation:____
____
____

Musculoskeletal

_____Neck pain _____Muscle pains _____Back pains where:__________
_____Joint pains where:____
Other joint or bone problems:____
____

Neuropsychological

_____Seizures _____Areas of numbness _____Poor memory _____Concussion
_____Depression _____Anxiety _____Bad temper _____Easily stressed
_____Treated for emotional problems:____
Other neurological or psychological problems:____
____
____