Intake Questionnaire

Patient Information

Name: ____

Age: _________ **Date of Birth:** ______________

Gender: ☐ Female ☐Male ☐Other ______________________

Address: ____

Telephone: Cell _____________________ Alternate ________________________

Email: ____

Emergency contact: _____________________________ Phone ______________

Primary caregiver: ______________________________ Phone ______________

Thank you in advance for your time and thoughtfulness in completing the following detailed intake questionnaire. All of this information will be used to provide you with optimum care!

Health Information

If you have written records for sections of this questionnaire please provide them as **additional documents** to this form.

If the form does not provide enough space for some sections **add extra pages as needed**.

Health Concerns

Please list your health concerns (in order of importance) and how long each concern or condition has been present.

1. Concern: ______________________________________ How long? ___________________
2. Concern: ______________________________________ How long? ___________________
3. Concern: ______________________________________ How long? ___________________
4. Concern: ______________________________________ How long? ___________________
5. Concern: ______________________________________ How long? ___________________

More information on your number one concern:

What do you think is the cause?

____

____

____

If you have been treated for this condition, what method or medicine was used?

____

____

Please check each box that applies:

- ☐ Is getting worse
- ☐ Is constant
- ☐ Is worse in the morning
- ☐ Is worse in the afternoon
- ☐ Is worse in the evening
- ☐ Interferes with school/work
- ☐ Interferes with sleep
- ☐ Interferes with movement/exercise
- ☐ Have had this or similar in the past
- ☐ Notice it more ______________________

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When was your last visit to a doctor's office, medical clinic or hospital? What was the reason?

____

____

____

Date of last physical exam: ___________________

Any abnormal findings? If yes, please explain. ____

____

____

Are you currently under the care of a health care practitioner? If yes, please explain.

____

____

____

____

Social History

Occupation: ______________________________________

(circle) Full-Time / Part-Time / Student / Retired / Disability

Employer / School ______________________________________

Are you: *(circle)* Single / Married / Long-term relationship / Widowed / Divorced /

Other ______________

Name of partner: ______________________________________

Number of children and ages? ____

Have you ever been assaulted verbally, sexually, or physically? Y N

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Medical History

What hospitalizations and/or surgeries have you had? Please add the dates.

1. ____
2. ____
3. ____
4. ____
5. ____
6. ____

What diagnostic imaging studies have you had?

- ☐ Bone Density Scan (DEXA)
- ☐ Colonoscopy
- ☐ CT Scan
- ☐ Endoscopy
- ☐ ECG/EKG
- ☐ EEG
- ☐ Echocardiogram
- ☐ Laparoscopy
- ☐ Mammogram
- ☐ MRI
- ☐ PET Scan
- ☐ Ultrasound
- ☐ X-ray
- ☐ Other ________________________

Have you had the following childhood illnesses?

- ☐ Chicken Pox
- ☐ Diphtheria
- ☐ German measles
- ☐ Measles
- ☐ Mumps
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Strep throat
- ☐ Other ________________________

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Current Health

Family's Health	Mother	Father	Siblings	Grandparents
Good				
Average				
Poor				
Age, if living				
Age, when deceased				
Cause of death				

Health Habits	Yes	No	*If yes*, please explain or give frequency?
Do you exercise?			
Do you smoke/chew tobacco? Past or present use?			
Do you drink alcoholic beverages?			
Do you use recreational drugs?			
Have you ever been treated for drug or alcohol dependence?			
Do you drink coffee, soda, or black tea?			
Do you drink "diet" sodas or eat "diet" foods?			
Are you familiar with "safe sex practices"?			
Do you follow any dietary modifications?			
Do you follow a spiritual practice?			
Do you have any hobbies or interests? What do you love to do?			

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General Review					
Do you…	**Yes**	**No**		**General Review – cont.**	
Sleep well?				Current weight?	
Wake feeling rested?				Weight one year ago?	
Eat three meals daily?				Max. adult weight/Date?	
Enjoy your work?				Min. adult weight/Date?	
Spend time outside?				Max adult height?	
Take vacations?				Best energy level? (What time of day)…	
Watch television? Hours/week…				Lowest energy level? (What time of day)…	
Read? Hours/week…				Subjectively, do you feel your temperature runs warm or cool?	
Use a computer? Hours/day?...				Are you a morning, afternoon, or night person?	

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Review of Systems

Circle **C** for current and/or **P** for past.

Blood/ Peripheral Vascular
C P Anemia
C P Cold hands/feet
C P Deep leg pain
C P Easy bleeding/ bruising
C P Thrombophlebitis
C P Varicose veins

Cardiovascular
C P Chest pain/pressure
C P Fainting/Light-headedness
C P Low blood pressure
C P High blood pressure
C P High cholesterol
C P Heart beat, irregular
C P Heart murmur
C P Palpitations, fluttering
C P Rheumatic fever
C P Swelling in ankles

Endocrine
C P Fatigue
C P Heat or cold intolerance
C P Hypoglycemia
C P Hypo/hyperthyroid
C P Increasing hunger
C P Increasing thirst
C P Night sweats
C P Seasonal depression

Neck
C P Goiter (Enlarged thyroid)
C P Lumps/Swollen glands
C P Pain or stiffness
C P Whiplash injury

Neurologic
C P Loss of memory
C P Numbness or tingling
C P Paralysis
C P Seizures
C P Tremor

Mental/Emotional
C P Anxiety, nervousness
C P Poor memory
C P Depression
C P Concentration, difficult
C P Contemplated suicide
C P Critical of others
C P Critical of self
C P Experience loneliness
C P Mood swings
C P Tension, stress
C P Treatment for mental/ emotional concerns

Head
C P Headaches
C P Head injury
C P Jaw or TMJ problems
C P Migraines

Nose and Sinuses
C P Hay fever
C P Nose bleeds
C P Runny nose
C P Sinus problems
C P Stuffiness, congestion

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Eyes

C P Blurriness
C P Cataracts
C P Color blindness
C P Diminished night vision
C P Dryness, excessive
C P Itchy eyes
C P Eye pain
C P Glasses or contacts
C P Glaucoma
C P Retinal detachment
C P Spots in eyes
C P Tearing, excessive

Respiratory

C P Asthma
C P Bronchitis
C P Cough, chronic
C P Difficulty breathing
C P Emphysema
C P Pain with breathing
C P Pneumonia
C P Pleurisy
C P Shortness of breath
C P At night
C P Lying down
C P With exercise/exertion
C P Spitting up blood
C P Sputum
C P Wheezing

Mouth and Throat

C P Bad breath
C P Dental cavities/fillings
C P Dentures
C P Frequent sore throat
C P Frequently clearing throat
C P Gum problems
C P Hoarseness
C P Metallic taste in mouth
C P Mouth sores
C P Saliva, excess
C P Sore tongue, lips
C P Teeth grinding

Ears

C P Dizziness/Vertigo
C P Earache
C P Ear infections
C P Ears, itchy
C P Hearing, impaired
C P Ringing, tinnitus
C P Wax, excessive

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Urinary

C P Bed wetting
C P BPH (Benign Prostatic Hypertrophy)
C P Frequency at night
C P Frequent infections
C P Increased frequency
C P Inability to hold urine
C P Kidney stones
C P Kidney, low-back pain
C P Low force of urine
C P Pain with urination
C P Urine retention
C P Urgency with urination

Musculoskeletal C P

C P Arch supports/heel lifts
C P Arthritis
C P Back pain
C P Broken bones
C P Joint pain or stiffness
C P Joint swelling
C P Muscle pain
C P Muscle spasms/cramps
C P Muscle weakness, tiredness
C P Osteoporosis/osteopenia
C P Sciatica

Skin and Hair

C P Acne
C P Boils
C P Cancer
C P Color change
C P Eczema
C P Flushing/hot flashes
C P Hair loss
C P Hives
C P Itching
C P Lumps
C P Moles
C P Psoriasis
C P Rashes
C P Rosacea
C P Skin Tag(s)

Gastrointestinal

C P Abdominal pain, cramps
C P Alternating diarrhea/constipation
C P Belching
C P Blood in stool
C P Change in stool
C P Bowel movements, how often? (#)__per day/2days/3 days/week
C P Bulimia
C P Change in appetite
C P Change in thirst
C P Constipation
C P Diarrhea
C P Fatigue after eating
C P Flatulence/gas
C P Gallbladder disease
C P Heartburn
C P Hemorrhoids
C P Hepatitis
C P Jaundice
C P Liver disease
C P Nausea
C P Pain in rectum
C P Painful stool
C P Parasites, diagnosed
C P Reflux
C P Stomach pain
C P Trouble swallowing
C P Vomiting

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Reproductive, Female

Age of first menses __________ Avg. duration of blood flow __________(days)

Number of days between menstrual cycles __________(days)

Date of last menstrual period ____________ Are your cycles regular**?** **Y** **N**

Are you pregnant**?** **Y** **N** Age of last period (if menopausal) _______________

Date of last annual exam/PAP _______________

Do you do self-breast exams**?** **Y** **N** How often? _____________________________

Number of: Pregnancies _____ Live Births _____ Miscarriages _____ Abortions _____

Reproductive, Male

Please check (√) the box for any that apply to you:

- ☐ Birth Control __________________
- ☐ Vasectomy
- ☐ BPH
- ☐ Ejaculation concerns
- ☐ Fertility concerns
- ☐ Impotence
- ☐ Penile discharges
- ☐ Penile sores
- ☐ Prostate disease
- ☐ Currently sexually active
- ☐ Sexual difficulties
- ☐ Sexually transmitted infections? _____________________________
- ☐ Testicular masses
- ☐ Testicular pain

Date of last prostate exam? _________________

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Medications

Please list all current pharmaceutical medications, dosages, and length of use.

1. ____
2. ____
3. ____
4. ____
5. ____

Are you allergic to any medications? If yes, please note them and your reaction.

____
____
____

Any other allergies to food or allergens in the environment? If yes, please note them and your reaction.

____
____
____

Supplements

Please list all herbs, nutrients, vitamins, minerals, or homeopathic remedies you are taking, and the dosage.

1. ____
2. ____
3. ____
4. ____
5. ____

Health Goals

Please tell me a little about what you expect from me as your practitioner and I will do my best to meet your needs!

____
____
____