INTAKE FORM - I

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New Client Intake Form (Please print or write clearly) Date ____________

Name____________________________________ Home Phone ___________________

Address __________________________________ Cell Phone ____________________

City ____________________State ___ ZIP ______ Work Phone ___________________

Occupation _______________________ Birthdate ___/___/_____ Age _____ Sex _____

Height ____________ Weight __________ Referred by __________________________

In case of emergency notify ____

Relationship _____________________

Their Home Phone ____________ Work Phone____________ Cell Phone____________

Physician _______________________________ Physician's Phone _________________

Physician Address ____
Street City State ZIP code

Reason for today's visit? ____
____
____
____
____
____

How long have you had this condition? _________ Have you had it in the past? _______
If "yes" in the past, describe when ____
What makes it better? ____
What makes it worse? ____
Is your condition… getting worse___ getting better___ constant___ comes and goes___
If applicable, circle a number to indicate your level of difficulty.
Minimal = 1 2 3 4 5 6 7 8 9 10 = Extreme

If you have a diagnosis, what is it? ____
Diagnosing physician __________________________________
Are any other practitioners treating this condition? Y / N _____
Are you under the care of another physician for any other problems? (List problem and physician) ____
____

What kinds of treatments have you tried? ______________________________________
____

What was occurring in your life when your difficulties began? ______________________
____

Please describe any important events occurring at that time or since then that may have started the difficulties of that contribute to them ___________________________________

____

Please list all medications, hormones, laxatives, herbs, homeopathics and supplements you are taking and for what reason ____
____
____

Please list allergies to any medications ____
____

Medical History

Date of your last physical exam __________ By whom? __________________________
List surgeries and dates ____
____
____

Significant accidents, hospitalizations and traumas with dates: ______________________
____
____

Do you or have you ever had (circle and mark year):

AIDS, ARC or HIV	Kidney or bladder trouble	Cancer
Dyslexia	Thyroid problems	Hepatitis
IDADHD	Hemophilia	Liver disease
Sexually transmitted disease	Rheumatic fever	Scarlet Fever
Epilepsy	Polio	Ulcer
Gallstones	Scarlet fever	Depression
Sudden weight loss	Neuralgia	Anxiety
Blood transfusions	Hemorrhoids	Emphysema
Mononucleosis	Malaria	Pneumonia
Arthritis	Yellow jaundice	Eczema
High blood pressure	German measles	Hives/rashes
High cholesterol	Pancreatitis	Bronchitis
Heart trouble	Tuberculosis	Diverticulosis

Have you ever taken adrenal corticosteroids (cortisone, prednisone, etc.)? Y / N _____
How long ________________________________
How many courses of antibiotics have you had? _________
Do you have silver amalgam fillings? ________
Unusual birth history (prolonged labor, forceps delivery, C-section, etc.)? ____________
Please list accidents/surgeries and location of scars _____________________________
____
What inoculations have you had? Tetanus (lockjaw) ___ Smallpox ___ Diphtheria ___
Poliomyelitis ___ Pertussis (whooping cough) ___ Rubella (German measles) ___
Flu ___ Other ____________
What inoculations have you had in the last year? __________________________________

Where have you traveled outside this country? ___________________________________

*** Please circle all that apply and list year when occurred ***

Family Medical History

Alcoholism	Anemia	Liver disease
Allergies/asthma	Diabetes	Stomach/ulcers
Arthritis	Epilepsy	Lung disease
Gout	Heart disease	Psychological problems
Asthma	Glaucoma	Stroke
Cancer/tumors	High blood pressure	Genetic diseases
Coronary artery disease	Kidney disease	

Musculoskeletal

Neck pain/stiffness	Mid back pain/stiffness	Leg or calf cramping
Shoulderblade pain	Low back pain/stiffness	Ankle pain/stiffness
Shoulder joint pain/stiffness	Sacroiliac pain/stiffness	Weak ankles
Upper arm pain/stiffness	Hip joint pain/stiffness	Foot or toe pain/stiffness
Elbow pain/stiffness	Pain into thigh or upper leg	Numbness or tingling in feet
Wrist pain/stiffness	Pain into calf or lower leg	Muscle spasm
Hand or finger pain/stiffness	Weak legs	Muscle weakness
Numbness or tingling in hands	Knee pain/stiffness	Paralysis
Upper back pain/stiffness	Weak knees	Stiff all over

Is the problem helped by pressure ___ heat ___ cold___ other ___________________

Is the problem aggravated by pressure ___ heat ___ cold___ other _________________

Gastrointestinal

Constipation	Black stool	Stomach acidity
Hard stools	Hemorrhoids	Indigestion
Bowel movements feel incomplete	Colitis	Gurgling noise in stomach
Frequent laxative use	Diverticulitis	Bad breath
Diarrhea	Parasites	Excessive appetite
Loose stools	Abdominal bloating	Poor appetite
Erratic bowel movements	Gas (flatulence)	Excessive thirst
Fowl smelling stools	Mucous in stool	Nausea
Undigested food in stool	Hiatal hernia	Vomiting
Gained/lost more than 10 pounds	Lower abdominal pain/cramping	Bloated
Blood in stool	Upper abdominal pain/cramping	Belching
		Ulcer
		Difficulty swallowing

How often do you have a bowel movement? _____________

Cardiovascular

High blood pressure	Rapid heartbeat/palpitations	High cholesterol
Low blood pressure	Dizzy spells	Stroke
Blackouts or fainting	Shortness of breath	Blood clot
Irregular heartbeat	Angina or chest pain	Phlebitis
Heart valve problem/murmur	Coronary heart disease	Leg cramps

Varicose veins
Bruise easily
Anemia
Edema
Swelling of hands
Swelling of feet
Cold hands
Cold feet
Hot hands of palms
Hot feet or soles
Generally too hot
Generally too cold

Skin and Hair

Rashes
Hives
Itching
Burning skin
Eczema
Psoriasis
Bruise easily
Bleed easily
Herpes Zoster (shingles)
Boils
Pimples or acne
Ulcerations or sores
Recent moles
Recent change in mole
Warts
Dry skin
Moist feet
Moist palms
Fungus on skin
Fungus under nails
Weak or brittle nails
Loss of hair
Dandruff

Any numb areas? _____ Where? ____

Eyes

Nearsighted (myopia)
Farsighted (hyperopia)
Astigmatism
Glaucoma
Cataracts
See halo
See double
Night blindness
Sensitivity to light
Blurred vision
Floating spots
Pressure behind eyes
Eye pain
Dry eyes
Watery eyes
Itchy eyes
Red eyes
Conjunctivitis
Use eyeglasses or contacts
Blindness
Eye infections

Sleep

Difficulty falling asleep, wired
Shallow sleep
Dream disturbed sleep
Nightmares
Wake at night—thinking
Wake at night—mind empty, eyes open
Snoring
Difficulty waking in a.m.
Wake up unrefreshed
Sleepy in afternoon
Need to take naps
Sleep too much
Sleep too little
Sleep on a waterbed
Sleep with an electric blanket

How many hours do you sleep in a 24-hour period? ______________

Urinary and Genital

Scanty or small amount of urine
Dark urine
Strong smelling urine
Cloudy urine
Profuse or large amount of urine
Clear urine
Unable to hold urine
Urgency to urinate
Frequent urination
Difficulty urinating
Decreased flow of urine
Flow does not stop quickly
Dribbling
Bed wetting
Pain or burning when urinating
Pain in bladder area
Blood in urine
Bladder infection
Kidney infection
Kidney stones
Lumps on testicles
Painful testicles
Sores on genitals
Pain during intercourse
Low sexual energy
Excessive sexual energy
Inability to achieve orgasm
Prostate problems
Low sperm count
Ejaculation during sleep
Premature ejaculation
Inability to maintain erection

How often do you urinate in 24 hours? ____ How often do you wake to urinate at night? ___

Any other problems with your urinary system? ____________________________________

Pregnancy and Gynecology

Number of pregnancies
Number of births
Premature births
Miscarriages
Abortions
Difficult deliveries
Caesarean sections
Age of children
Age at first menses
Starting date of last menses
Duration of flow
Length of cycle
Age at start of menopause
Age menses stopped
Hysterectomy
  Reason for
Oophorectomy
  Reason for
Have not yet begun menstruating
Irregular flow
Clots
  dark purple
  dark brown
  red

Heavy flow
Light flow
Light colored/pale blood
Painful periods
Endometriosis
Cramping before period starts
Cramping after period starts
Low backache with period
Spotting between periods
Vaginal discharge
  no odor
  strong odor brownish
  white/curd-like
  frothy & profuse
  itchy
  burning
Missed periods
Premenstrual irritability
Premenstrual emotional sensitivity
Premenstrual breast tenderness
Premenstrual bloating
Premenstrual fluid retention

Premenstrual headache
Premenstrual constipation
Premenstrual diarrhea
Hot flashes
Abnormal pap
Uterine fibroids
Ovarian cysts
Breast cysts or lumps
Pelvic inflammatory disease
Currently have an IUD
Previously had an IUD
Current use of birth control pills
Previous use of birth control pills
Other birth control
____
Cannot maintain pregnancy
Trying to become pregnant
Infertility
Pregnant
Nausea or morning sickness
Nursing

Any other pregnancy or gynecological problems? ____________________________________

Date of last pap test _____________

Respiratory

Chronic cough
Dry cough
Tight, rattling cough
Loose cough
Thick, sticky phlegm
Thin, watery phlegm
Clear or white phlegm

Yellowish phlegm
Blood in phlegm
Bronchitis
Pneumonia
Pain with deep breath
Shortness of breath
Emphysema

Wheezing
Asthma, more difficult to exhale
Asthma, more difficult to inhale
Asthma, worse on exhaling
Frequent chest colds

Head, Ears, Nose, Mouth, Throat and Neurological

Frequent colds
Sinus congestion or pain
Facial pain
Jaw tension or clicking (TMJ)
Grinding teeth
Frequent dental cavities
Gum problems
Bleeding gums
Dentures
Dizziness or loss of balance

Convulsions
Trembles
Concussion
Seizures
Faintness
Numbness
Changes in handwriting
Headache
Migraine headache
Congestion in ears

Earache
Ringing in ears
Difficulty hearing
Motion sickness
Deafness
Nasal congestion
Runny nose
Nose bleeds
Sneezing
Allergies

Decreased sense of smell	Sores on tongue	Sore throat
Dry mouth	Sores in mouth (canker)	Strep throat
Excessive saliva or drooling	Sores of lips (fever blister)	Swollen lymph nodes
Taste in mouth	Difficulty swallowing	Tonsillitis
Taste changes	Lump or pit in throat	

General

Head or chest cold	Jaundice	Recent weigh loss
Flu	Armpits or groin swellings	Recent weight gain
Recurrent fever	Anemia	Often thirsty
Chills	Always fatigued	Seldom thirsty
Night sweats	Fatigued easily	Alcohol use
Perspire easily w/o exertion	Sudden drop in energy	Smoking
Rarely perspire	Recreational or hard drugs	

Emotional

Depression	Mood swings	Worry a lot
Suicidal feelings	Manic episodes	Frequent crying
Frequent anger or irritation	Obsessiveness or compulsiveness	Anxiety or fear
Tendency to repress emotions	Sadness or grief	Indecisiveness
Lonely	Loses temper easily	Difficulty handling stress
Frightening dreams or thoughts	Lack of concentration or memory	Difficulty relaxing
Sexual difficulties		Shy or sensitive
		Desired psychiatric help

Have you ever been emotionally, physically or sexually abused? ____________________

Have you ever been treated for emotional problems? ______________________________

Have you recently had any unusually stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)? Describe. _________________________

Is there a constant stress in your life, at work, with your family, etc. _________________

Any other emotional problems? ____