SEASONS IN OUR LIFE

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INTAKE FORM - I

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

Name_____ Home Phone _____

Address _____ Cell Phone _____

City _____State ___ ZIP _____ Work Phone _____

Occupation _____ Email _____

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 _____

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 _____

_____

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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	Ulcer
Epilepsy	Polio	Depression
Gallstones	Scarlet fever	Anxiety
Sudden weight loss	Neuralgia	Emphysema
Blood transfusions	Hemorrhoids	Pneumonia
Mononucleosis	Malaria	Eczema
Arthritis	Yellow jaundice	Hives/rashes
High blood pressure	German measles	Bronchitis
High cholesterol	Pancreatitis	Diverticulosis
Heart trouble	Tuberculosis	

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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	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
Shoulder blade pain	Low back pain/stiffness	Ankle pain/stiffness
Shoulder joint pain/stiffness	Sacroiliac pain/stiffness	Numbness or tingling in feet
Upper arm pain/stiffness	Hip joint pain/stiffness	Foot or toe pain/stiffness
Elbow pain/stiffness	Pain into thigh or upper leg	Weak ankles
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

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

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

Gastrointestinal

Constipation	Hemorrhoids	Gurgling noise in stomach

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

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How often do you have a bowel movement? _____

Cardiovascular

High blood pressure	Coronary heart disease	Edema
Low blood pressure	High cholesterol	Swelling of hands
Blackouts or fainting	Stroke	Swelling of feet
Irregular heartbeat	Blood clot	Cold hands
Heart valve problem/murmur	Phlebitis	Cold feet
Rapid heartbeat/palpitations	Leg cramps	Hot palms
Dizzy spells	Varicose veins	Hot feet or soles
Shortness of breath	Bruise easily	Generally too hot
Angina or chest pain	Anemia	Generally too cold

Skin and Hair

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

Any numb areas? _____ Where? _____

Eyes

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

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Sleep

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

	a.m.	blanket

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

Urinary and Genital

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

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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	Light flow	Uterine fibroids
Number of births	Light colored/pale blood	Ovarian cysts
Premature births	Painful periods	Breast cysts or lumps
Miscarriages	Endometriosis	Pelvic inflammatory disease
Abortions	Cramping before period starts	Current use of birth control pills

Difficult deliveries	Cramping after period starts	Previous use of birth control pills
Caesarean sections	Low backache with period	Currently have an IUD
Age of children	Spotting between periods	Previously had an IUD
Age at first menses	Missed periods	Other birth control: _____
Starting date of last menses	Premenstrual irritability	Cannot maintain pregnancy
Duration of flow	Premenstrual emotional sensitivity	Trying to become pregnant
Length of cycle	Premenstrual breast tenderness	Infertility
Age at start of menopause	Premenstrual bloating	Pregnant
Age menses stopped	Premenstrual fluid retention	Nursing
Have not yet begun menstruating	Premenstrual headache	Nausea or morning sickness
Hysterectomy Reason for:	Premenstrual constipation	Clots dark purple dark brown red
Oophorectomy Reason for:	Premenstrual diarrhea	Vaginal discharge no odor strong odor, brownish white/curd-like frothy & profuse itchy burning
Irregular flow	Hot flashes	
Heavy flow	Abnormal pap	

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Any other pregnancy or gynecological problems? _____

Date of last pap test _____

Respiratory

Chronic cough	Yellowish phlegm	Wheezing
Dry cough	Blood in phlegm	Frequent chest colds
Tight, rattling cough	Bronchitis	Asthma, worse on exhaling
Loose cough	Pneumonia	Asthma, more difficult to inhale
Thick, stick phlegm	Pain with deep breath	Asthma, more difficult to exhale
Thin, watery phlegm	Shortness of breath	
Clear or water phlegm	Emphysema	

Head, Ears, Nose, Mouth, Throat and Neurological

Frequent colds	Numbness	Decreased sense of smell
Sinus congestion or pain	Changes in handwriting	Dry mouth
Facial pain	Headache	Excessive saliva or drooling
Jaw tension or clicking (TMJ)	Migraine headache	Taste in mouth
Grinding teeth	Congestion in ears	Taste changes
Frequent dental cavities	Earache	Sores on tongue
Gum problems	Ringing in ears	Sores in mouth (canker)
Bleeding gums	Difficulty hearing	Sores of lips (fever blister)
Dentures	Motion sickness	Difficulty swallowing
Dizziness or loss of balance	Deafness	Lump or pit in throat
Convulsions	Nasal congestion	Sore throat
Trembles	Runny nose	Strep throat
Concussion	Nose bleeds	Swollen lymph nodes
Seizures	Sneezing	Tonsillitis
Faintness	Allergies	

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General

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

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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 constant stress in your life, at work, with your family, etc. _____

_____

_____

Any other emotional problems? _____

_____

_____

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