New Patient Medical History Intake Form

Name: _____ Todays Date: _____ / _____ /_____

Date of Birth: _____ / _____ /_____ Age: _____ Gender: M / F Marital Status: S M D W

Address:		
City:	State:	Zip Code
Primary Ph.# (cell, hm, wk)	2nd Ph.: (cell, hm, wk)	
Email Address	Occupation	
Emergency Contact(s)	Phone:	
	Phone:	
How did you find us ?		

Please complete this questionnaire as thoroughly as possible. Successful health care and preventative medicine are only possible when the practitioner has a complete understanding of the patient physically, mentally and emotionally.

1. When did you last receive healthcare?

Why ? _____ Date: _____

2. Please identify the health concerns that you have brought here today, in order of most extreme

A. _____

_____

On-set date: _____

B. _____

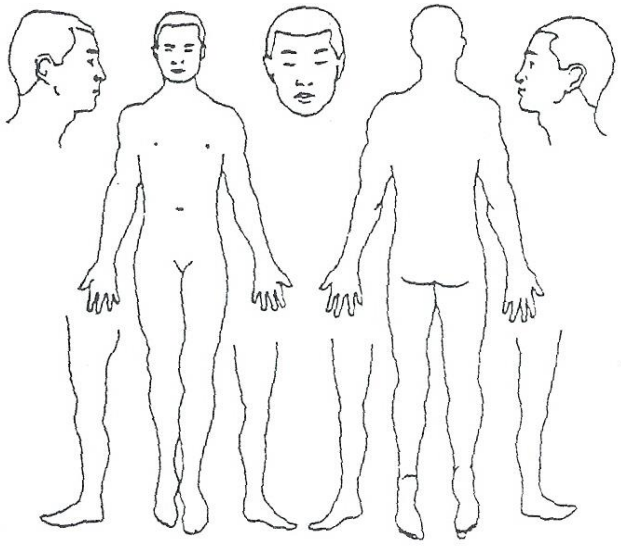
_____

On-set date: _____

C. _____

_____

On-set date: _____



3. Height _____ Current Weight _____ Past Maximum: _____ How Long ago: _____

What was your most recent blood pressure reading? _____ / _____ When ? _____

4. Please List any medications and supplements you are currently taking: ***(write on back side for more space)***

Medications	For what reason ?	**Supplements**	For what reason?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

5. Please list all foods, medications, or other materials you are **hypersensitive** or ***allergic*** to. *(Please include reaction)*

_____

_____

_____

6. Family History: *Please designate if Self, Mother, Father, Sibling*

Cardiac Pacemaker	Bleeding Disorder	HIV
Heart Attack	Diabetes	Rheumatoid Arthritis
Seizure Disorder	Fainting Disorder	Hepatitis B or C
Stroke	Cancer	Other: _____

7. Surgeries and Hospitalizations *(Please include when and why)*

_____

_____

_____

_____

_____

8. Urination: ***(check all that apply)***

Normal color (pale yellow)		History if UTI	☐
Clear	☐	Has odor	☐
Dark Yellow	☐	Burning	☐
Reddish	☐	Painful	☐
Cloudy	☐	Difficult	☐
Scanty	☐	Urgent	☐

9. Sleep Patterns *(check all that apply)*

Awake Rested	☐	Nightmares	☐
Do not awake rested	☐	Dream a lot	☐
Hard to fall asleep	☐	Awake early, unable to go back to sleep	☐
Hard to stay asleep	☐	other: _____	☐

10. Cravings: *check all the apply*

sweet	☐	crunchy	☐
bitter or tart	☐	fatty	☐
spicy	☐	other: _____	☐
salty	☐		

11A. <u>Men Only</u>: *Please put a check mark by the symptoms that pertain to you*

Feeling of coldness or numbness in the external genitalia ☐
Pain or swelling of testicles ☐
Premature ejaculation ☐
Impotence / erectile dysfunction ☐

11B. <u>Women Only</u>: *Please answer all that symptoms that pertain to you*

Age of first period: _____
Are you currently pregnant: Y / N
Number of Children: _____
<u>Menstrual Cycle:</u>
Average number of days of flow
The Flow is: normal, heavy, light
The color is: normal, dark, purple, light brown, brown, bright red, light red / pink
Do you have PMS ? Y / N / Sometimes
Mild to Moderate Scale: 1 2 3 4 5 6 7 8 9 10

Premenopausal or Menopause	☐	Bleeding between cycles	☐
Irregular cycle	☐	Clotting	☐
Vaginal discharge	☐	Premenstrual symptoms (PMS)	☐
Nipple discharge	☐	Breast lumps / tenderness	☐
Heavy flow	☐	Difficulty conceiving	☐
Painful periods	☐		

Please include any additional information related to your menstrual cycle in the white space above::
==========

12. Current or Previous Symptoms:

Please put a <u>checkmark</u> by the symptoms that are current to you / and a 'P' for <u>*past*</u> symptom:

Hot flashes	☐	Cold Hands and Feet	☐
Bloodshot eyes / dry eyes	☐	Hair loss	☐
Heat sensations in hands, feet or chest	☐	Not awaking rested	☐
Angers easily	☐	Varicose veins	☐
.Chronic cough	☐	Tight feeling in chest	☐
TM\J / grinding teeth	☐	Fatigue	☐
Sinus congestion	☐	Foggy Head	☐
Shortness of breath (inhale or exhale)	☐	Sweat at night	☐
Skin dryness	☐	Skin Rashes	☐
Low appetite	☐	Catch colds and Flu easily	☐
Large appetite	☐	Headaches	☐
Loose stools	☐	Sweat easily	☐
Constipation	☐	Numbness of hands or feet	☐
Alternating Diarrhea with constipation	☐	Dizziness	☐
Chronic infections	☐	Muscle spasms, twitching, cramping	☐
Asthma	☐	See floaters (eyes)	☐
Tendency to over think or worry	☐	Seizure or convulsions	☐
Abdominal Bloating or gas after eating	☐	Mood swings	☐
Frequent sore throats	☐	Sore weak and/ or cold knees	☐
Feeling tired after eating	☐	Heart murmur	☐

Stiff neck and upper back	☐	Sore on tip of tongue	☐
Chills with alternation fever	☐	Low back pain	☐
Prolapse organs (previously diagnosed)	☐	High Blood pressure	☐
General feeling of heaviness in the body	☐	Anxiety	☐
Mental Sluggishness	☐	Frequent urination	☐
Feeling of sadness or depression	☐	Startled by unexpected noises	☐
Swollen hands or feet	☐	Palpitations	☐
Burning sensation after eating	☐	Lack of bladder control	☐
Bad breath	☐	Memory issues	☐
Mouth sores (cancer sores)	☐	Hemorrhoids	☐
Bleeding swollen gums	☐	Ankle swelling	☐
Stomach pain / stomach ulcer	☐	Bruise easily	☐
Vomiting and nausea	☐	Difficult breathing	☐
Low libido	☐	Slow healing wounds	☐
Excessively high libido	☐	Insomnia	☐
Heartburn / Belching	☐	Bitter taste in mouth	☐
Does not like change	☐		

13. Lifestyle:

Do you typically eat at least three meals per day? _____ If no, explain: _____

Exercise routine: _____

Spiritual practice: _____

How many hours per night do you sleep? _____ If no, how many? _____ Do you wake rested? _____

Occupation: _____ Do you enjoy work? _____ How many hours per week : _____

Level of education completed: High School Bachelors Masters Doctorate Other: _____

Have you experienced any major trauma(s) ? _____

Do you drink Caffeine? _____ Coffee / Tea / Other How many caffeinated beverage per week ? _____

Do you smoke currently ? _____ Do you drink alcohol ? _____ How Many beverages to you have per week ? _____

How many glasses of water do you drink per day ? _____

Television habits: _____ Reading habits: _____

Interests and hobbies: _____

If there was one thing you could do, make, or create, given all the resources you needed to succeed …

What would it ***be*** / What would you do ?? _____

_____

I AM INTERESTED IN (Please check <u>all</u> that apply)

Nutrition _____ Weight Loss / Detoxification _____ Hormone and NT Balancing _____

Newsletter _____ Spiritual Advancement _____ Local Events _____