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#: 2nd Ph:

(cell, home, work): (cell, home, work):

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. On what date did you last receive healthcare?

Why ?

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

(Use diagrams below to indicate areas specified in Section A, B and C)

A.

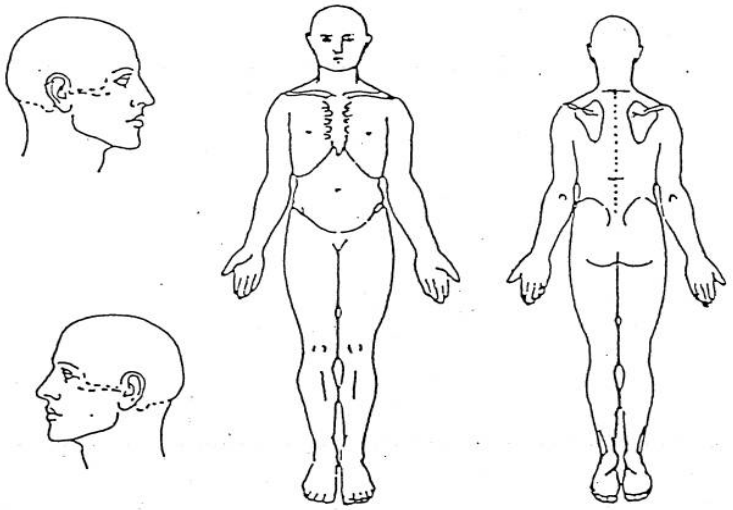
Onset date:

B.

Onset date:

C.

Onset 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)
- ☐ Clear
- ☐ Dark yellow
- ☐ Reddish
- ☐ Cloudy
- ☐ Scanty
- ☐ History of UTI
- ☐ Has odor
- ☐ Burning
- ☐ Painful
- ☐ Difficult
- ☐ Urgent

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

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

10. Cravings: *check all the apply*

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

11A. Men Only: *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. Women Only: *Please answer all that pertain to you*

Age of first period:

Are you currently pregnant: Y / N

Number of Children:

Menstrual Cycle:

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

Please put a check mark by the symptoms that pertain to you

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

Please include any additional information related to your menstrual cycle in the space below::

12. Current or Previous Symptoms:

Please put a checkmark by the symptoms that are current to you / and those that are a *past* symptom:

Current	Past		Current	Past	
☐	☐	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

Current	Past		Current	Past	
☐	☐	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? ☐ Do you wake rested? ☐

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

Level of education completed: ☐ High School ☐ Bachelors ☐ Masters ☐ Doctorate ☐ Other (Explain:)

Have you experienced any major trauma(s)? Describe:

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 & NT Balancing
☐	Newsletter	☐	Local Events	☐	Spiritual Advancement		