Patient Intake Form

Date: _____

Name: _____

Date of Birth: _____ Age: _____ Gender: _____

Address:_____

Phone: _____ Email: _____

Emergency Contact: _____ Relationship to Patient: _____

Emergency Contact Phone Number: _____

Primary Heathcare Provider and/or Clinic: _____

Address: _____

Phone: _____

Your answers to the following questions will help us learn more about you and your health. Please take a few minutes to complete this questionnaire; you may skip any questions you are uncomfortable answering.

1. What is your chief complaint today? _____

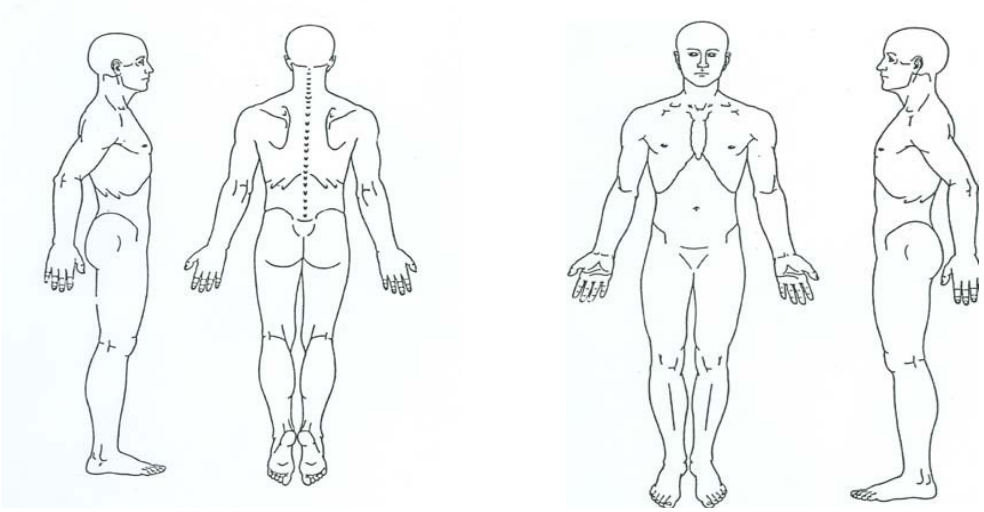
_____

Check all that apply.

- ❑ Neck / Back / Joint pain
- ❑ Headaches
- ❑ Depression /Anxiety
- ❑ Respiratory Problems (e.g., asthma, allergies, sinus congestion)
- ❑ Digestive Problems (e.g., poor appetite, heartburn, constipation, diarrhea)
- ❑ Urinary Problems (e.g., difficult or painful urination, kidney stones)
- ❑ Fatigue or Low Energy
- ❑ Female Reproductive Health (e.g., PMS, menopause, infertility)
- ❑ Male Reproductive Health (e.g., enlarged prostate, erectile dysfunction)
- ❑ Stress Management
- ❑ General Wellness
- ❑ Other: _____

Please mark on the body forms with an "X" where you are experiencing any pain of other discomfort. Next to the "X", use the symbols to indicate the **type of pain** you have experienced **in the past week**.

Numbness	Pins and Needles	Burning	Stabbing	Aching	Other
====	00000	xxxx	/////	++++	****



2. Health History

Please list any health problems you currently have or have had. Answer to the best of your knowledge.

- Cancer (malignant or metastatic):

_____

- Diabetes (Type I or II):

_____

- Infectious Diseases (e.g., hepatitis, HIV):

_____

- Heart, Lungs or Circulation (e.g., asthma, high blood pressure, previous heart attack):

_____

- Digestive System (e.g., poor appetite, heartburn, constipation, diarrhea):

_____

- Psychosocial Health (e.g., depression, anxiety, violence toward self or others):

_____

- Skeleton and Joints (e.g., arthritis, back or neck pain):

_____

- Genitourinary System (e.g., difficult or painful urination, kidney stones, STD's):

_____

- Nervous System (e.g., headache, dizziness, multiple sclerosis, Parkinson's disease):

_____

- Eyes, ears, nose and throat (e.g., loss of vision or hearing, ringing in ears, dental problems):

_____

- Skin (e.g., rashes, sores, moles that have changed):

_____

- Chronic Immune System deficiencies (e.g., colds, sinusitis, bronchitis):

_____

- Men's Health problems (e.g., enlarged prostate, erectile dysfunction):

_____

- Women's Health problems (e.g., dysmenorrhea, pelvic inflammatory disease, uterine fibroids):

_____

- Other: _____

Family Health History
Do/Did any members of your immediate family (mother, father, sister, brother) have any serious health conditions?

- ❑ No
- ❑ Yes → Please describe your relation to this individual and their condition.

Please list any allergies:

Please list any surgeries you have had in the past, and their date.

Please list any traumas or injuries.

Please list:

Current Medication	**Dose**	**Purpose**	**Prescribed by:**

How many children do you have? _____

Females only, please list:
Number of pregnancies _____
Number of births _____

Have you had preventive health screenings for the following (check all that apply)?

- ❑ Blood pressure within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Breast exam within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Pap smear within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Prostate exam within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Colonoscopy within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Fasting blood glucose within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Cholesterol within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Blood lipids within the last __month __6 month __year __5 yrs __5+ yrs __Never
- ❑ Dental within the last __month __6 month __year __5 yrs __5+ yrs __Never

3. How often do you typically consume alcoholic drinks (e.g. beer, wine)?
___ every day ___ some days ___ not at all

4. How often do you typically consume caffeinated drinks (e.g. coffee, soda)?
___ every day ___ some days ___ not at all

5. Do you use tobacco products (e.g. cigarettes, chewing tobacco, pipe)?
___ Yes, currently ___ Yes, in the past (year quit _____) ____ No, never

6. On average, how much physical activity, exercise, or sports activities have you taken part in during the past month?
___ None ___ Less than 1 time/week ___1 time/week ___ 2-3 times/week ___4+ times/week

Please reflect on your sense of well-being, taking into account your physical, mental, emotional, social and spiritual condition over the past month. Mark the line below with an 'X' at the point that summarizes your **overall sense of well-being** for the past month.

_____

Worst you have ever been — Best you have ever been

7. What is your marital status? (Please check most current status)
- ❑ Married or living with significant other
- ❑ Divorced / Separated
- ❑ Widowed
- ❑ Never been married

8. How much schooling have you completed? (Please check one)
- ❑ Completed less than high school
- ❑ Graduated from high school
- ❑ Completed 1-3 years of college
- ❑ Graduated from a 2-year Associate Degree program or technical school
- ❑ Graduated from college
- ❑ Completed post-graduate or professional program

9. Please identify your race, as defined by the federal government. (Please check one)
- ❑ Asian or Pacific Islander
- ❑ Black / African American
- ❑ Hispanic
- ❑ American Indian or Alaskan Native
- ❑ White
- ❑ Other _____