PATIENT INTAKE FORM

NAME:	**PHONE:**	**CELL:**
ADDRESS:	**AGE:**	**HT:** **WT:**
CITY:	**D.O.B.:**	**SEX:**
STATE: **ZIP:**	**OCCUPATION:**	
PHYSICIAN:	**REFERRED BY:**	**EMERGENCY#:**
MAIN PROBLEM:		**ONSET:**
OTHER CONCURRENT THERAPIES:		

PAST MEDICAL HISTORY (include dates):

SIGNIFICANT ILLNESSES: ———CANCER ———DIABETES ———HIGH BLOOD PRESSURE ———HEART DISEASE ———HEPATITIS ———RHEUMATIC FEVER ———THYROID DISEASE ———SEIZURES ———OTHER

SURGERIES:

SIGNIFICANT TRAUMA: (AUTO ACCIDENT, FALLS, ETC.)

BIRTH HISTORY: (PROLONGED LABOR, FORCEPS DELIVERY, ETC.)

ALLERGIES: (DRUGS, CHEMICALS, FOODS)

MEDICINES TAKEN WITHIN THE LAST TWO MONTHS: (INCLUDE VITAMINS, OVER-THE-COUNTER DRUGS, HERBS, ETC.)

OCCUPATIONAL STRESSES: (CHEMICAL, PHYSICAL, PSYCHOLOGICAL, ETC.)

EXERCISE:

COMMENTS:

AVERAGE DAILY DIET:

MORNING AFTERNOON EVENING

HABITS: CIGARETTES COFFEE TEA COLA ALCOHOL DRUGS SUGAR SALT OTHER

FAMILY MEDICAL HISTORY: ———DIABETES ———CANCER ———HIGH BLOOD PRESSURE ———HEART DISEASE ———STROKE ———SEIZURES ———ASTHMA ———ALLERGIES ———ALCOHOLISM ———OTHER

NOTES:

GENERAL:

- ❑ POOR APPETITE
- ❑ HEAVY APPETITE
- ❑ POOR SLEEP
- ❑ HEAVY SLEEP
- ❑ INSOMNIA
- ❑ FATIGUE
- ❑ TREMORS
- ❑ VERTIGO
- ❑ COLD HANDS
- ❑ COLD FEET
- ❑ COLD BACK
- ❑ COLD ABDOMEN
- ❑ FEVERS
- ❑ CHILLS
- ❑ NIGHT SWEATS
- ❑ SWEAT EASILY
- ❑ CRAVINGS
- ❑ LOCALIZED WEAKNESS
- ❑ POOR CONDITION
- ❑ CHANGE IN APPETITE
- ❑ SUDDEN ENERGY DROP AT _____ (TIME)
- ❑ PECULIAR TASTES/SMELLS _____
- ❑ STRONG THIRST (COLD/HOT DRINKS)_____
- ❑ BLEED OR BRUISE EASILY (WHERE)_____

SKIN & HAIR:

- ❑ RASHES
- ❑ ULCERATIONS
- ❑ HIVES
- ❑ ITCHING
- ❑ ECZEMA
- ❑ PIMPLES
- ❑ DANDRUFF
- ❑ LOSS OF HAIR
- ❑ CHANGE IN HAIR/SKIN TEXTURE
- ❑ PURPURA
- ❑ OTHER HAIR AND SKIN PROBLEM_____

HEAD, EYES, EARS, NOSE, & THROAT:

- ❑ DIZZINESS
- ❑ CONCUSSIONS
- ❑ MIGRAINES
- ❑ GLASSES
- ❑ EYE STRAIN
- ❑ EYE PAIN
- ❑ POOR VISION
- ❑ NIGHT BLINDNESS
- ❑ COLOR BLINDNESS
- ❑ CATARACTS
- ❑ BLURRY VISION
- ❑ EARACHES
- ❑ RINGING IN EARS
- ❑ POOR HEARING
- ❑ NOSE BLEEDS
- ❑ SINUS PROBLEMS
- ❑ MUCUS
- ❑ DRY THROAT
- ❑ DRY MOUTH
- ❑ COPIUS SALIVA
- ❑ TEETH PROBLEMS
- ❑ JAW CLICKS
- ❑ GRINDING TEETH
- ❑ FACIAL PAIN
- ❑ GM PROBLEMS
- ❑ SPOTS IN EYES
- ❑ RECURRENT SORE THROATS_____/MONTH
- ❑ SORES ON LIPS OR TONGUE
- ❑ HEADACHES (WHERE & WHEN)_____
- ❑ OTHER HEAD OR NECK PROBLEMS

CARDIOVASCULAR:

- ❑ HIGH BLOOD PRESSURE
- ❑ LOW BLOOD PRESSURE
- ❑ CHEST PAIN
- ❑ IRREGULAR HEARTBEAT
- ❑ DIZZINESS
- ❑ FAINTING
- ❑ COLD HANDS / FEET
- ❑ SWELLING IN HANDS / FEET
- ❑ BLOOD CLOTS
- ❑ PHLEBITIS
- ❑ DIFFICULTY BREATHING
- ❑ OTHER

RESPIRATORY:

- ❑ COUGHING
- ❑ COUGHING BLOOD
- ❑ ASTHMA
- ❑ TIGHT CHEST
- ❑ PNEUMONIA
- ❑ DIFFICULTY IN BREATHING WHEN LYING DOWN
- ❑ BRONCHITIS
- ❑ PRODUCTION OF PHLEGM_____WHAT COLOR_____
- ❑ OTHER LUNG PROBLEMS_____

GASTROINTESTINAL:

- ❑ NAUSEA
- ❑ VOMITING
- ❑ DIARRHEA
- BOWEL MOVEMENT:
- ❑ GAS
- ❑ BELCHING
- ❑ BLACK STOOLS
- _____FREQUENCY
- ❑ BAD BREATH
- ❑ RECTAL PAIN
- ❑ HEMORRHOIDS
- _____COLOR
- ❑ CONSTIPATION
- ❑ BLOODY STOOLS
- ❑ SENSITIVE ABDOMEN
- _____ODOR
- ❑ PAIN OR CRAMPS
- ❑ LAXATIVE USE:_____ / WEEK; TYPE_____
- _____TEXTURE / FORM

GENITO - URINARY:

- ❑ PAIN ON URINATION
- ❑ FREQUENT URINATION
- ❑ BLOOD IN URINE
- ❑ URGENCY TO URINATE
- ❑ UNABLE TO HOLD URINE
- ❑ KIDNEY STONES
- ❑ VENEREAL DISEASE
- ❑ IMPOTENCY
- ❑ WAKE UP TO URINATE HOW OFTEN_____ / NIGHT; TIME:_____
- ❑ OTHER G / U PROBLEMS

PREGNANCY & GYNECOLOGY:

- ❑ NUMBER OF PREGNANCIES
- ❑ NUMBER BIRTHS
- ❑ PREMATURE BIRTHS
- ❑ MISCARRIAGES
- ❑ AGE AT FIST MENSES
- ❑ PERIOD (DAYS)
- ❑ DURATION
- ❑ IRREGULAR PERIODS
- ❑ FLOW (DESCRIBE)
- ❑ CLOTS
- LAST PAP_____
- LAST MENSES_____
- ❑ VAGINAL DISCHARGE
- ❑ VAGINAL SORES
- ❑ BREAST LUMPS
- MENOPAUSE_____
- ❑ BIRTH CONTROL TYPE & DURATION_____
- ❑ CHANGES IN BODY / PSYCHE PRIOR TO MENSTRUATION

MUSCULOSKELETAL:

- ❑ NECK PAIN
- ❑ MUSCLE PAINS
- ❑ BACK PAIN (WHERE) _____
- ❑ JOINT PAINS (WHERE) _____
- ❑ OTHER JOINT OR BONE PROBLEMS?

NEUROPSYCHOLOGICAL:

- ❑ SEIZURES
- ❑ AREAS OF NUMBNESS
- ❑ POOR MEMORY
- ❑ CONCUSSION
- ❑ DEPRESSION
- ❑ ANXIETY
- ❑ BAD TEMPER
- ❑ EASILY STRESSED
- ❑ TREATED FOR EMOTIONAL PROBLEMS
- ❑ CONSIDERED / ATTEMPTED SUICIDE
- ❑ OTHER NEUROLOGICAL OR PSYCHOLOGICAL PROBLEMS?

FOR CLINIC TO FILL OUT:

CLASSICAL

PREFERENCES	*MOST LIKED*	*LEAST LIKED*
SEASON		
TASTE		
CLIMATE		
TIME OF DAY		
TEMPERATURE		

COMMENTS: