PRINT

General Intake Form

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General Information:

Name: _____ Sex: ☐ M ☐ F Marital Status: Single Birth Date: _____
Address: _____
City: _____ Postal Code: _____
Phone: Home: (___)_____ Work: (___)_____ Cell: (___)_____
Occupation: _____ Email: _____
Next of Kin: _____ Phone #: _____
Name/address of present physician(s): _____
How did you learn of this clinic?_____

Height: Current Weight: _____ Lowest adult weight: _____ Max weight: _____Height:_____

Please describe your major concerns and/or symptoms. Please be clear and concise to help us help you better. Include when the symptoms first began. What you can in the space provided. If you need more space, please attach the separate piece of paper provided. _____

_____

_____

If you have seen other physicians for these concerns, indicate the results of these evaluations: _____

_____

_____

_____

Please bring medical records, if possible, especially lab tests or hospital discharge summaries.

What habits, activities or attitudes do you consider to have contributed to any of your concerns? _____

_____

_____

Are you currently receiving psychiatric care or undergoing psychological counseling? ☐ **Y** **N** ☐

Health History: Please indicate if you have any of the following conditions:

☐ Kidney disease	☐ Diabetes	☐ Migraines	☐ Headaches	☐ Hypoglycemia	☐ Breast feeding
☐ Stroke	☐ Depression	☐ Asthma	☐ Gout	☐ Cancer	☐ Skin condition
☐ Allergies	☐ Lung disease	☐ Anemia	☐ Arthritis	☐ Fainting	☐ Mental illness
☐ Hemorrhoids	☐ Fibromyalgia	☐ Acne	☐ Anorexia	☐ Anxiety	☐ Bloating/gas
☐ Indigestion	☐ Bronchitis	☐ Cold sores	☐ Constipation	☐ Dandruff	☐ Diarrhea
☐ Weight gain	☐ Weight loss	☐ Emphysema	☐ HIV	☐ Hair loss	☐ Heartburn
☐ Herpes	☐ Hot flashes	☐ Insomnia	☐ Confusion	☐ Kidney stones	☐ Cirrhosis
☐ Liver disease	☐ Loose stool	☐ Poor memory		☐ Panic attacks	☐ Ulcer
☐ Incontinence	☐ Hearing loss	☐ Respiratory problems		☐ Suicidal tendencies	
☐ Pneumonia	☐ Poor nail growth			☐ Gallbladder removed	
☐ Thyroid problems	☐ High cholesterol			☐ Addiction (drugs/alcohol)	
☐ Chronic Fatigue	☐ Intestinal problems			☐ Chronic cold or flu symptoms	
☐ Bladder infections	☐ Viral or bacterial disease			☐ High blood pressure	
☐ Ringing in the ears	☐ Neurological disease			☐ Irregular menstruation	
☐ Painful menstruation	☐ Loss of menstruation			☐ Painful intercourse	
☐ Menopause	☐ Endometriosis			☐ Infertility	

☐ Other: _____

Please list any **previous** illnesses, accidents, and hospitalizations you have had including dates: _____

Please list medications, vitamins, minerals, and supplements you are presently taking: _____

Do you have allergies or sensitivities to any medications? Please name drugs and reactions). _____

Medical History: Please indicate which of the following conditions you or your family has beside each condition.
(Parents, siblings, aunts, uncles, grandparents, etc)

Alcoholism: _____ High Cholesterol: _____
Allergies: _____ Frequent Infections: _____
Arthritis: _____ Urinary Tract Infections: _____
Anemia: _____ Polio: _____
Angina: _____ Lupus: _____
Asthma: _____ Mental Illness: _____
Bleeding/Bruising: _____ Migraines/Headaches: _____
Cancer: _____ Pneumonia: _____
Convulsions/Epilepsy: _____ Prostate Problems: _____
Crohn's Disease: _____ Sinus Problems: _____
Diabetes: _____ Strokes: _____
Digestive Disorders: _____ Heart Attacks: _____
Herpes/Shingles: _____ Thyroid Problems: _____
Hypoglycemia: _____ Tuberculosis: _____
Drug Problems: _____ Ulcers: _____
Eczema/Psoriasis: _____ Weight Problems: _____
Hepatitis: _____ Rheumatic Fever: _____
High Blood Pressure: _____ Venereal Disease: _____
Other: _____

Previous Medical Tests: If know, please specify date of test and results. If possible, please bring most recent results to the first appointment.

Last physical exam: _____ Stress test: _____
X-rays: _____ Angiogram: _____
GI series: _____ Ultrasound tests: _____
Kidney/bladder series: _____ Catheterization: _____
Gallbladder tests: _____ Blood tests: _____
EKG: _____ Allergy testing: _____
Other: _____

Previous Immunizations: Specify when if known:

Small Pox: _____ Tetanus: _____ Polio: _____
Flu: _____ Mumps: _____ Measles: _____
Rubella: _____ Pneumonia: _____ Diphtheria: _____
Pertussis: _____ Other: _____

Have you ever been on prolonged antibiotic therapy or have you used them frequently? (I.E. Erythromycin, Penicillin, Tetracycline, Sulfa Drugs, Flagyl, etc.)_____

Lifestyle:
Do you smoke? ☐ **Y** ☐ **N** (if yes, when did you start and how often do you smoke? _____
Did you ever smoke? ☐ **Y** ☐ **N** When did you start? _____ When did you quit? _____
How long did you smoke? _____
Are you regularly exposed to second hand smoke? ☐ **Y** ☐ **N** Where? _____

Do you use recreational drugs? ☐ **Y** ☐ **N**
If yes, when did you start and how often do you use them? _____
What types of recreational drugs have you used? _____

What types of non-prescription medications do you use? (i.e. laxatives, antihistamines, decongestants, analgesics, stimulants, etc.)_____
_____

Do you have any other allergies or sensitivities? (food, pollens, animals, chemicals, etc) _____
_____

Are you regularly exposed to industrial or environmental chemicals, pollution, smog, or pesticides? ☐ **Y** ☐ **N**
If you answered Yes, which ones are you exposed to? _____

Do you currently have any pets? ☐ **Y** ☐ **N**

Describe the emotional climate of your home/work? _____
_____
_____

What do you do to relax? (I.e. hobbies) _____
_____
_____

Do you exercise regularly? ☐ **Y** ☐ **N**
How often do you exercise? _____ Length of session: _____
What type of exercise do you do? _____

Which of the following illnesses have you had as a child?

☐ Colic	☐ Pneumonia	☐ Learning Disability Hyperactivity
☐ Eczema	☐ Meningitis	☐ German measles
☐ Asthma	☐ Rheumatic Fever	☐ Bedwetting
☐ Polio	☐ Recurrent Colds	☐ Tonsillectomy
☐ Allergies	☐ Ear Infections	☐ Persistent Diaper Rash
☐ Bronchitis	☐ Thrush	

☐ Other: _____

Have you ever traveled out of the country? ☐ **Y** ☐ **N** Have you ever had "Traveler's Diarrhea?" ☐ **Y** ☐ **N**
Have you ever been treated for parasites? ☐ **Y** ☐ **N** Have you ever been tested for intestinal parasites? ☐ **Y** ☐ **N**

How much sleep do you get per night? _____
How often do you have a bowel movement? _____