



New Patient Medical History Intake Form

Name: _____

Today's Date: ____ / ____ / ____

Date of Birth: ____ / ____ / ____

Age: _____

Gender: M / F

Marital Status: S M D W

Address:

City:

State:

Zip Code

Primary Ph#

2nd Ph:

(cell, hm, wk)

(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. _____

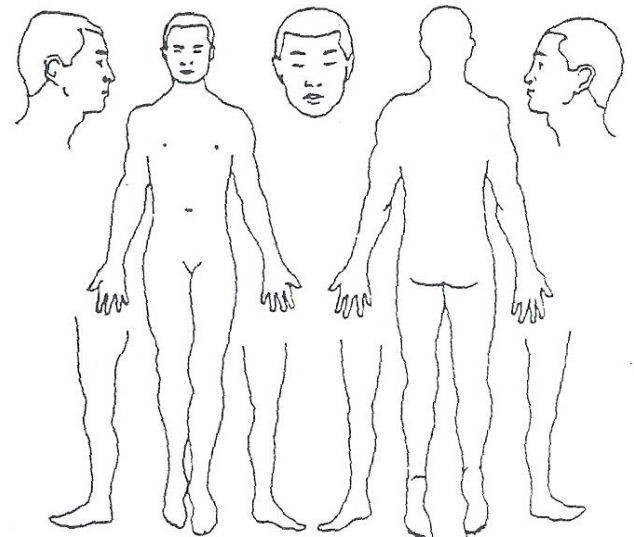
On-set date: _____

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)

<u>Medications</u>	<u>For what reason ?</u>	<u>Supplements</u>	<u>For what reason?</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

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)	<input type="checkbox"/>	History if UTI	<input type="checkbox"/>
Clear	<input type="checkbox"/>	Has odor	<input type="checkbox"/>
Dark Yellow	<input type="checkbox"/>	Burning	<input type="checkbox"/>
Reddish	<input type="checkbox"/>	Painful	<input type="checkbox"/>
Cloudy	<input type="checkbox"/>	Difficult	<input type="checkbox"/>
Scanty	<input type="checkbox"/>	Urgent	<input type="checkbox"/>

9. Sleep Patterns (check all that apply)

Awake Rested	<input type="checkbox"/>	Nightmares	<input type="checkbox"/>
Do not awake rested	<input type="checkbox"/>	Dream a lot	<input type="checkbox"/>
Hard to fall asleep	<input type="checkbox"/>	Awake early, unable to go back to sleep	<input type="checkbox"/>
Hard to stay asleep	<input type="checkbox"/>	other: _____	<input type="checkbox"/>

10. Cravings: check all the apply

sweet	<input type="checkbox"/>	crunchy	<input type="checkbox"/>
bitter or tart	<input type="checkbox"/>	fatty	<input type="checkbox"/>
spicy	<input type="checkbox"/>	other: _____	<input type="checkbox"/>
salty	<input type="checkbox"/>		

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 symptoms 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

- Premenopausal 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 white space above::

12. Current or Previous Symptoms:

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

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

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

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 all that apply)

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

Newsletter _____ Spiritual Advancement _____ Local Events _____