Patient Intake Form

Your health is very important to us. **Please take your time.** All information is held in strict confidentiality.

Patient Name:_____ Date of Birth:_____ Today's Date:_____

What Health Issues You Would Like To Address (In Order of Importance):

1) _____
2) _____
3) _____
4) _____
5) _____

Primary Care Physician:_____ Office Location:_____

Date of Last Physical:_____ Physician's Comments:_____

List All Surgeries, Hospitalizations, Bone Fractures, Traumas & Date:

1)_____ 4)_____
2)_____ 5)_____
3)_____ 6)_____

List Any Known Allergies (Foods, Penicillin, Sulfa Drugs, Codeine, Medications, Latex, etc.):

1)_____ 3)_____ 5)_____
2)_____ 4)_____ 6)_____

Personal History **(Review Carefully)** **C**=**C**urrently **P**=**P**ast **N**=**N**ever

	C	P	N		C	P	N		C	P	N
High Blood Pressure				Diabetes				Seizures			
Asthma				Blood Clotting Problems				Tumor / Cancer			
Arthritis				Recurrent Fever				Urination Problems			
Heart Problems				Headaches				Mental Illness			
Night Sweats				Vision Problems				Auto-Immune Condition			
Frequent Colds / Flu				Whiplash				Serious Auto Accident			
Falls / Slips				Dizziness				Kidney Issues			
Shortness of Breath				Ehlers-Danlos				Pneumonia			
Tuberculosis				Heart Arrhythmias				Heartburn			
Unexplained Weight Loss				Varicosities				Hepatitis			
Muscle Cramps				Sciatica				Fainting			
Panic Attacks				Depression				Anxiety			
Insomnia				Stroke				Concussion			
Parasites				Smoking / Tobacco				Alcoholism / Drug Abuse			
Ulcer				Ringing of Ears				Sleep Apnea			
Fibromyalgia				Sports Injury				Coldness of Hands or Feet			
Numbness / Tingling				Rashes / Skin Problems				Joint Pain			
Loss of Hearing				Prostate Issues							

Other:_____

_____

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History of Abnormal Lab Values:
(Please circle if yes)

Sed rate, CRP (C-reactive protein), Rheumatoid factor, ANA (Lupus), or Lyme, Other:_____

_____

Have you been prescribed any of the following antibiotics? (Cipro, Levaquin or Tequin):_____
(Please circle if yes)

_____

Describe previous or current organ problems:_____

_____

All current medications & dose_____

_____

_____

Vitamins, supplements taken daily & dose:_____

_____

_____

Describe daily energy level:_____

Hours of quality sleep per night:___ Hours of exercise per week:_____ Hours of work per week:____

Bowel movements per day: ___ Stools are usually: Loose Firm Normal Undigested Food: Y N

Drink times per day: Water____ Soda_____ Coffee_____ Tea_____ Alcohol____ Diet Soda____

Any known exposure to toxins / chemicals / radiation - past or present - (work, home, etc.):_____

_____

Routine activities / sports:_____

Sports / activities of youth:_____

_____

Childhood & young adult fractures / traumas / injuries / accidents (age & bone / joint)_____

_____

_____

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Family History

Briefly list health issues:

Father:_____

Mother:_____

Siblings:_____

Other:_____

Patient signature:_____ Date:_____

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