

Patient Initial Intake

Name: _____ Date of Birth: _____

List of Complaints (in order of importance):

1. _____
2. _____
3. _____
4. _____
5. _____

Current Medications and Supplements (include dosage):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Past Medical, Surgical & Trauma History (list prior illness, injury, hospitalizations, surgeries, and/or trauma, include dates):

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Allergies (Medications and Food): _____

Who is your primary care provider: _____

Please list date of your last:

Physical: _____ Blood Work: _____ Dental Screening: _____ Eye Exam: _____

Please indicate if you have had the disease (D) or were immunized (I):

Measles: D I Mumps: D I Rubella: D I Hemophilis (Hib): D I Tetanus: D I
Shingles: D I Chicken Pox: D I Hepatitis B: D I Whooping Cough: D I
German Measles: D I HPV (Gardasil): D I Other Vaccinations: _____

Please indicate Yes (Y), No (N), or Past (P):

Antacids: Y N P Smoking: Y N P Packs per day & number of years _____
Analgesics: Y N P Coffee: Y N P Cups per day if yes or passed _____ Laxatives: Y N P
Alcohol: Y N P Type: _____ Amount if yes or passed _____
Steroids: Y N P Soda: Y N P Amount if yes or passed _____
Recreational Drugs Y N P
Addictions and/or treatment for addictions: Y N P Explain: _____

Diet:

Typical breakfast: _____
Typical lunch: _____
Typical dinner: _____
How many ounces of water do you drink per day: _____
Other drinks & amounts (coffee, soda, juice, sports drinks): _____

Exercise:

How often: _____ Type: _____

Height: _____ Current Weight: _____ Ideal Weight: _____

Maximum Weight as Adult: _____ Minimum Weight as adult: _____

Sleep:

Amount: _____ Wake Refreshed? _____

Social History:

Job: _____ Enjoy Job? _____

Hobbies: _____

Highest level of education completed: _____

Define Religion/Spiritual Status: _____

Do you find your life: Satisfactory Unsatisfactory Too Demanding Boring

Childhood memories: Mostly happy Mostly painful Normal Don't recall

Relationship: Married Single In a relationship

Satisfied with Significant Relationship? _____

Children & ages: _____

Major stresses in last 6 months? Money Job Marriage Home life Children

Other: _____

Do you manage stress well? _____

History of Mental/Physical/emotional Abuse? _____ If so, what age & by whom? _____

Family History

Family Member	Age if Living	Age of Death	Illness(es)/Reason of Death
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

Disease	Family Member
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	
Diabetes	

Review of Systems

Circle Yes (Y), No (N) or Passed (P):

General:

Weight Change: Y N P	Appetite Change: Y N P	Fever/Chills: Y N P
Weakness: Y N P	Fatigue: Y N P	Night Sweats: Y N P

Skin:

Rash: Y N P	Eczema: Y N P	Color Change: Y N P
Hives: Y N P	Cancer: Y N P	Abnormal Mole: Y N P
Psoriasis: Y N P	Warts: Y N P	Dry/ Itchy: Y N P
Hair/Nail change: Y N P	Acne: Y N P	

Head:

Migraines: Y N P	Dandruff: Y N P	Oily/dry Hair: Y N P
Headache: Y N P	Hair Loss: Y N P	Head Injury: Y N P
Dizziness: Y N P	Lightheadedness: Y N P	

Eyes:

Dryness: Y N P	Cataracts: Y N P	Pain: Y N P
Itching: Y N P	Glaucoma: Y N P	Watery/Discharge: Y N P
Redness: Y N P	Styes: Y N P	Vision Problems: Y N P
Eye Strain: Y N P	Dark circles: Y N P	Contacts/Glasses: Y N P
Last Eye exam: _____		

Ears:

Ringing: Y N P	Discharge: Y N P	Pain: Y N P
Change in hearing: Y N P	Recurrent infections: Y N P	Vertigo: Y N P

Nose:

Nose bleeds: Y N P	Allergies: Y N P	Frequent Colds: Y N P
Polyps: Y N P	Congestion: Y N P	Problems Smelling: Y N P
Post Nasal Drip: Y N P	Sinusitis: Y N P	Discharge: Y N P

Mouth/Throat/Neck:

Cavities: Y N P	Goiter: Y N P	Problems Speaking: Y N P
Dentures: Y N P	Gum Disease: Y N P	Problems Tasting: Y N P
Sores: Y N P	Sore Throat: Y N P	Problems Swallowing: Y N P
Last Dental Appointment: _____	Cold Sores: Y N P	Hoarseness: Y N P
Swollen Glands: Y N P	Neck Stiffness: Y N P	Neck pain: Y N P
Full Neck Movement: Y N P		

Respiratory:

Asthma: Y N P	Cough: Y N P	Emphysema: Y N P
Shortness of Breath with Exertion: Y N P	Shortness of Breath with Sitting: Y N P	Shortness of Breath with Lying Down: Y N P
TB: Y N P	Wheezing: Y N P	Coughing blood: Y N P
Pneumonia: Y N P	Bronchitis: Y N P	Pain with Breathing: Y N P

Cardiovascular:

Palpitations: Y N P	Heart Attack: Y N P	High Blood Pressure: Y N P
Chest Pain: Y N P	Rheumatic Fever: Y N P	Arrhythmias: Y N P
Murmurs: Y N P	Edema: Y N P	Low Blood Pressure: Y N P
Angina: Y N P	Congestive Heart Failure: Y N P	Leg Cramps: Y N P
Varicose Veins: Y N P	Sleep > 2 Pillows: Y N P	Blue Hands/Feet: Y N P

Gastrointestinal:

Heartburn: Y N P	Vomiting: Y N P	Nausea: Y N P
Indigestion: Y N P	Ulcers: Y N P	Gall Bladder Disease: Y N P
Gas/Bloating: Y N P	Hemorrhoids: Y N P	Pancreatitis: Y N P
Constipation: Y N P	Liver Disease: Y N P	Abdominal Pain: Y N P
Diarrhea: Y N P	Nausea: Y N P	Fatty Meals Bother: Y N P
Blood/Mucus in Stools: Y N P	Change in Appetite: Y N P	Hernias: Y N P
Rectal Bleeding/Burning/Itching: Y N P	Food Intolerance: Y N P	Bowel Movements per day: _____

Urinary Tract:

Incontinence: Y N P	Kidney Stones: Y N P	Frequent Infections: Y N P
Urgency: Y N P	Blood in Urine: Y N P	Pain with Urination: Y N P
Frequent Urination: Y N P	Waking to Urinate: Y N P	

Female:

Age of First Menses: _____ First Day of Last Menses: _____ Length of Menses: _____
 How Often Period Occurs: _____ Cycle: Regular Irregular Color: _____
 Clots: _____ # Pads/Tampons on per day: Heavy day _____ Light day: _____
 Age of Menopause: _____ Age Mother/Grandmother entered menopause: _____
 Do you do self breast exams monthly: Y N Do you know how to: Y N
 Date of Last Mammogram: _____ Results: _____
 Date of Last Pap Smear: _____ Results: _____
 Have you ever had an irregular pap smear: Y N If yes, date/treatment: _____
 Date of last Dexa (Bone) Scan: _____ Results: _____
 Times Pregnant: _____ Miscarriages: _____ Abortions: _____ Complications: _____
 Currently sexually active: Y N 1 Partner >1 Partner If greater than 1, how many: _____
 Age of first sexual intercourse: _____ Number of sexual partners in lifetime: _____
 Birth control or other hormones previously or currently used: _____
 Satisfied Desire change
 Sexual Orientation: Heterosexual Homosexual Bisexual Other

Abnormal Paps: Y N P	Vaginal Discharge: Y N P	Pain with intercourse: Y N P
PMS: Y N P	Odor: Y N P	Healthy Libido: Y N P
STD: Y N P	Heavy Bleeding: Y N P	Sexually Active: Y N P
Vaginitis: Y N P	Vaginal Dryness: Y N P	Menstrual Cramping: Y N P
Hot flashes: Y N P	Breast Pain: Y N P	Breast Masses: Y N P
Breast Discharge: Y N P	Hernias: Y N P	Bloating: Y N P
Endometriosis: Y N P	Fibroids: Y N P	Ovarian cysts: Y N P
Ovarian/Uterine Cancer: Y N P	Food Cravings during Menses: Y N P	Hair growth on face: Y N P
Difficulty conceiving: Y N P	Irregular Bleeding: Y N P	

Male:

STD's	Y	N	P	Hernia:	Y	N	P	Erectile Difficulty:	Y	N	P
Discharge:	Y	N	P	Prostate Disease:	Y	N	P	Testicular Pain/Swelling:	Y	N	P
Pain:	Y	N	P	Sexually Active:	Y	N	P	Dribbling:	Y	N	P
Difficulty Initiating Urination:	Y	N	P	Healthy Libido:	Y	N	P	Incomplete Urination:	Y	N	P

Do you do monthly self testicular exams: _____

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Age of first sexual intercourse: _____ Number of sexual partners in lifetime: _____

Date of last PSA/Prostate Exam: _____

Musculoskeletal:

Weakness:	Y	N	P	Tremors:	Y	N	P	Leg Cramps:	Y	N	P
Stiffness:	Y	N	P	Arthritis:	Y	N	P	Pain:	Y	N	P
Past Injury:	Y	N	P	Back/Neck Pain:	Y	N	P	Muscle Aches:	Y	N	P

Nervous:

Paralysis:	Y	N	P	Sciatica:	Y	N	P	Numbness/Tingling:	Y	N	P
Seizures:	Y	N	P	Fainting:	Y	N	P	Carpel Tunnel:	Y	N	P
Fainting/Blackouts:	Y	N	P	Weakness:	Y	N	P	Tremors:	Y	N	P

Endocrine:

Weight Gain:	Y	N	P	Snack Often:	Y	N	P	Feel Bad When Not Eating Regularly:	Y	N	P
Weight Loss:	Y	N	P	Increased Thirst:	Y	N	P	Easy Bruising/Bleeding:	Y	N	P
Mood Swings:	Y	N	P	Irritability:	Y	N	P	Hot/Cold Intolerance:	Y	N	P
Increased Urination:	Y	N	P	Diabetes:	Y	N	P	Hormone Therapy:	Y	N	P
Thyroid Problem:	Y	N	P	Change in Glove/Shoe Size:	Y	N	P	Anemia:	Y	N	P

Energy:

Sleep Soundly:	Y	N	P	Wake Refreshed:	Y	N	P	Feel Energetic in the Morning:	Y	N	P
Heart Races:	Y	N	P	Easy Fatigue:	Y	N	P	Poor Memory:	Y	N	P
Afternoon Tiredness:	Y	N	P	Tired All Day:	Y	N	P	Tired No Matter How Much I Sleep:	Y	N	P
Wake at Night:	Y	N	P								

Mental/Emotional:

Feel Down/Depressed:	Y	N	P	Suicidal:	Y	N	P	Psych Hospitalization:	Y	N	P
Anxiety:	Y	N	P	Fear/Panic:	Y	N	P	Bipolar:	Y	N	P
Eating Disorder:	Y	N	P	Anger/Irritability:	Y	N	P	Obsessive:	Y	N	P

What is your greatest health concern? _____

How does it limit you? _____

How committed are you towards making valuable changes: Little Moderately Very