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Patient Intake Form

Name: _____Date _____

Address: _____

City:_____State: _____Zip Code: _____

Phone 1:_____Phone 2: _____

Phone number where messages can be left for you: _____

Email address: _____

Age: _____Date of birth:_____Gender:_____Health Insurance:_____

Your relationship status: _____Occupation: _____

Employer name: _____Hours worked per week: _____

Work address: _____

Emergency contact name: _____Relationship to you:_____

Contact address: _____ Phone:_____

What are your health concerns? *Please list them in the order of importance for you today.*

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

What are your goals for treatment? *Please describe them.*

1. _____
2. _____

How motivated are you to receive help and make changes for your health?

_____

Are you receiving health care somewhere else? *If yes, please list from whom and where their office is located.*

_____

_____

What health issues are you being treated for? _____

_____

Do you have any concerns with our office sharing information with your other provider(s)?

_____

Current Medications

Do you use any of the following? *Please check all the boxes that apply and write the name in the space afterwards.*

☐Antibiotics
☐Anti-inflammatory medications
☐Pain relievers
☐Cholesterol lowering medications
☐Stomach aids or digestive medications
☐Antidepressants
☐Other psychiatric medications
☐Blood pressure medications
☐Hormones of any kind
☐Sleeping Pills

Please list any other prescription medications, over-the-counter medications, vitamins, herbs, and nutritional supplements you use and how frequently. Include dosage if you can.

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

Diet, Lifestyle, and Habits

Please describe your typical daily meals

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____

Please describe what type of allergies or hypersensitivity reactions you notice:

Food: _____
Medications: _____
Chemicals: _____
Animals: _____

Do you use or identify with any of the following: *Please check all the boxes that apply.*

☐Fast food outlets
☐Coffee
☐Sodas
☐Canned foods
☐Teas (caffeinated)
☐Salt or sugar your foods
☐Cravings for sweets/salty starches
☐Afternoon or evening cravings
☐Reward yourself with food(s)
☐Cravings for comfort food(s)
☐Eat near bedtime or during night
☐Irritable if not eating regularly
☐History of dieting or food restrictions
☐History of eating disorder(s)
☐Tobacco
☐Alcohol
☐Marijuana
☐Other recreational drugs

Considering the past 6 months, please answer the following:

Describe what type of exercises you do and how frequently you did them.

_____

_____

How many hours would you typically spend in front of computers or televisions during a day/week?

_____

What areas in your life were the most common stressors? _____

What have been your hobbies or interests? _____

Describe your supportive relationships and/or communities/groups you participate in. _____

_____

Did you attend any religious ceremony or perform any spiritually oriented practice? _____*If you wish, please write about them.* _____

General

Height_____ Current weight_____ Weight 1 year ago? _____Preferred weight _____

Last physical exam _____ History of trauma? _____ History of abuse? _____

Review of Systems

In this section, check the box if you have the symptom currently or if you have experienced it in the past 6 months.

Mental/Emotional

☐Mood intensity or frequency concerns
☐Mood swings
☐Seasonal depression
☐Depression
☐Considered/attempted suicide
☐Poor concentration
☐Anxiety or nervousness
☐Tension or chronic stress feelings
☐Memory problems
☐Easily stressed
☐Sleep disruption or disturbance
☐Seasonal depression

Endocrine

☐Hair loss
☐Brittle nails
☐Excessive thirst
☐General fatigue
☐Fatigue after meals
☐Heat intolerance
☐Cold intolerance
☐Excessive hunger

Blood/Peripheral Vascular

☐Easy bleeding/bruising
☐Deep leg pain
☐Varicose veins
☐Anemia
☐Cold hands/feet

Immune

☐Chronic fatigue syndrome
☐Swollen glands
☐Reaction to vaccines
☐Ongoing infections
☐Slow wound healing
☐Colds/flu more than once yearly
☐Autoimmune disease
☐History of autoimmune disease in family

Head

☐Headaches
☐Migraines
☐Head injury
☐Jaw pain/TMJ

Ears
☐Impaired hearing
☐Earaches
☐Ringing
☐Itching inside or outside
☐Frequent popping

Nose and Sinuses
☐Frequent head colds
☐Stuffiness
☐Sinus pain
☐Nose bleeds
☐Hay fever
☐Loss of smell

Eyes
☐Spots in vision
☐Blurriness
☐Color blindness
☐Double vision
☐Cataracts
☐Eye pain/strain
☐Glaucoma
☐Uncomfortable tearing or dryness

Intestinal
☐Trouble swallowing
☐Change in thirst
☐Change in appetite
☐Nausea/vomiting
☐Burning pain in stomach
☐Heartburn
☐Jaundice
☐Gallbladder disease
☐Liver disease
☐Abdominal pain or cramps
☐Excessive belching or excess gas
☐Constipation
☐Diarrhea
☐Hemorrhoids
☐Black stools
☐Blood in stools
☐Bowel movement (BM) daily

Musculoskeletal
☐Joint pain or stiffness
☐Broken bones
☐Muscle spasms or cramps
☐Arthritis

Mouth and Throat
☐Frequent sore throat
☐Teeth grinding

Neck
☐Lumps
☐Goiter/enlargement in front of throat
☐Pain or stiffness

Respiratory
☐Cough
☐Asthma/wheezing
☐Difficulty breathing
☐Emphysema
☐Pain on breathing
☐Shortness of breath
☐Lung congestion/sputum
☐Bronchitis
☐Pleurisy
☐Pneumonia

Musculoskeletal (continued)
☐Weakness
☐Sciatica

Neurological
☐Seizures
☐Muscle weakness
☐Loss of memory
☐Vertigo/dizziness
☐Paralysis
☐Numbness or tingling

Cardiovascular
☐Heart disease
☐High blood pressure
☐Low blood pressure
☐Blood clots
☐Phlebitis
☐Rheumatic fever
☐Ankle swelling
☐Angina/chest pain
☐Heart murmurs
☐Fainting

Skin
☐Rashes/hives
☐Itchiness
☐Acne, boils
☐Color changes
☐Lumps
☐Eczema

Male Reproduction
(Questions apply to lifetime, not just last 6 months)
☐Hernias
☐Prostate disease
☐Impotence
☐Premature ejaculation
☐Testicular masses or pain
☐Discharge or sores on penis
☐Genital herpes

Sexuality
Are you sexually active_____

Sexual orientation (Please describe)_____
Use of birth control (What type)_____
History of STDs _____
Libido concerns_____

Urinary
☐Pain with urination
☐Urgency
☐Frequency at night
☐History of frequent infections
☐Unable to hold urine
☐Kidney stones
☐Splitting of stream

Female Reproduction
(Questions apply to lifetime, not just last 6 months)
Age at first menses (first period) _____
Age of last menses (if menopausal) _____
Date of last annual exam/Pap _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages_____
Usual length of cycle _____
Duration of menstruation _____
☐Bleeding/spotting between periods
☐PMS
☐Menopausal symptoms
☐Genital herpes
☐Pain with sexual activity

Please list any other health concerns you wish to address that have not been covered in this questionnaire:
_____

_____

How did you hear about our services? _____

Is there someone we can thank for your referral?_____

Your privacy is very important and our policy on protecting your confidentiality is available anytime upon request. Our office also uses electronic medical charts for record keeping and insurance billing. Please ask if you have any questions about these services and how you can access your medical file.

Dr. Garcia looks forward to working with you. Thank you for filling out this intake form. Please bring it with you to your appointment.

Your signature: _____ Date: _____