New Patient Intake Form

(ALL Information is confidential)

Personal Information

Name:_____

Address:_____

Home ph #_____Work ph #_____Cell ph #_____

E-mail Address:_____Relationship Status:_____

Birthdate:_____Age:_____Height:_____Weight:_____

Occupation/Employer_____Emergency Contact & Ph Number:_____

Referred by:_____

Current Medical History

Main problem(s) for which you would like help:_____

What, if any, medical diagnosis have you been given for this problem?_____

How long ago did this problem begin:_____Is it worse /better?_____

What makes it feel worse or better (heat/cold/pressure)?_____

What other treatment(s) have you tried?_____

How much does it interfere with your daily activities?_____

Do you wear a pacemaker or other implanted electrical device?_____

Past Medical History

Illnesses and accidents (Circle all that apply)

Cancer	Diabetes	Stroke	High Blood Pressure	Heart disease	Lung Disease	
Arteriosclerosis	Surgeries	Accidents	Seizures/epilepsy	Hepatitis	AIDS/HIV	Herpes

Stress (job,physical,relationship,etc.) other:_____

Family Medical History (Relationship and date)

Cancer	Diabetes	Heart Disease	High Blood Pressure	Stroke	Seizures
Alcoholism	Arteriosclerosis				

Other:_____

I understand that there is a 24-hour cancellation policy and that I am fully financially responsible for any appointments canceled within 24 hours of my appointment and that not signing this document does not release me from responsibility of payment.

_____ _____

Patient or authorized person's signature **Date**

Symptoms within last year

General

Poor /heavy appetite	Recent weight gain/loss	Energy drop after eating	Fatigue/lack of strength
Difficulty falling asleep	Wake up during night	Dream-disturbed sleep	Sweat easily/night sweats
Bruise easily	Aversion to: wind/cold/heat/damp	Rashes/hives	Eczema/psoriasis
Itching	Ulcerations	Hair loss	

Head, eyes, ears, nose, throat

Headaches	Migraines	Wear glasses/poor vision	Itchy/red/tearing eyes
Light sensitive	Spots/threads in front of eyes	Sinus problems - post nasal drip	Frequent dry or sore throat
Ringing in ears	Poor /loss of hearing	Dental/GUM problems	Grind teeth/TMJ

Cardiovascular/Respiratory

Chest pain	Difficulty breathing	Blood clots	Palpitations	Irregular heartbeat
High/low blood pressure	Fainting	Dizziness	Tight chest	Swelling of hands/feet
Cough - blood or phlegm	Pneumonia	Allergies	Asthma	Shortness of breath

Gastrointestinal

Nausea/vomiting	Acid regurgitation	Intestinal pain/cramping	Gas/belching/bloating
Diarrhea/constipation	Frequency of BM_____	Ease/urgency of stool	Hemorrhoids
Stools - bloody/black/mucus?			

Genitourinary

Pain on urination	Unable to hold urine	Frequent/urgent urination	Wake to urinate
Incomplete urination	Urine color: light/dark/blood	Kidney stone	Increased/Decreased libido
Sexually transmitted disease			

Musculoskeletal

Neck/Shoulder pain	Upper back pain	Lower back pain	Muscle pain/weakness
Hip pain	Knee pain	Ankle/Foot pain	Limited range of motion
Elbow pain	Wrist/Hand pain	Rib pain	Other:_____

Gynecology and pregnancy

PMS - cramps - irritability - breast tenderness - bloating - other (Circle all that apply)

Irregular/Painful periods	Clots	Heavy/Light flow?	Date last menses_____
Color of blood	Duration of flow	Length of cycle	Date of last PAP_____
Number of births	Number of miscarriages/abortions		Menopause_____

Neuropsychological

Dizziness	Lack of coordination/tremors	Seizures/tics/facial twitching	Loss of balance
Areas of numbness	Areas of Tingling	Concussion	Poor memory/confusion
Irritable/bad temper	Susceptible to stress/depression	Anxiety/panic	Seeing a therapist
Abuse survivor	Considered suicide	Attempted suicide	

Habits (Cigarettes Coffee Tea Cola Alcohol Drugs Sugar Salt)

*Allergies (drugs, chemicals, food)*_____

*Medications taken within last 2 months*_____

Childhood Influences

What event(s) occurred (or did not occur) when you were a child/young adult that strongly influenced your life? How do you feel about them?

_____

_____

_____