New Patient Intake

Date:_____

Preferred Name:_____

Legal Name:_____

Date of Birth_____

Address:_____

Phone:_____ Email_____

Gender:_____ Sex:_____

Relationship Status:_____

Emergency Contact:_____ Phone: _____

Reason for Appointment:_____

Medical History

Do you have a primary care physician? _____

Are you looking for a primary care physician? YES NO

What medications and supplements do you take regularly? Please include dosages if you know them:

_____

_____

_____

_____

Do you have any allergies to medications (or other)?

_____

Have you had any surgeries or hospitalizations? Please include dates it you know them:

_____

Any major illnesses?_____

For Children (**if not applicable, please skip to section Family History)

Weight at birth:_____ Were (are) they breastfed?_____
How long did breastfeeding continue?_____
If formula was introduced, at what age did this occur and for how long?:_____
Which vaccinations have they received?_____
Have they had any childhood illnesses? Please include dates if you know them:
_____
_____

Jaundice as baby:	Y N	**Colic:**	Y N
Cradle Cap:	Y N	**Anemia:**	Y N
Eczema or Psoriasis:	Y N	**Asthma:**	Y N
Diarrhea:	Y N	**Warts:**	Y N
Constipation:	Y N	**Nightmares:**	Y N
Enjoys wide range of foods:	Y N	**Bed-wetting:**	Y N
Cavities:	Y N	**Tantrums:**	Y N
Chronic Sniffles:	Y N	**Behavior concerns:**	Y N
Bad Foot Odor:	Y N	**Fears/Phobia:**	Y N
Very Sweaty Baby/Child:	Y N	**Diaper Rash:**	Y N
Hyperactivity:	Y N	**Early Puberty:**	Y N
Growing Pains:	Y N	**Stomach Aches:**	Y N

Any particular household stressors child has witnessed or gone through:
_____
_____
_____

Has the child ever lived in a house that had new carpeting, paint, cabinets or any other refurbishing that seemed to affect their health at all?

_____

_____

Family Medical History

Allergies: Y N Unknown **Obesity**: Y N Unknown **Cancer**: Y N Unknown
Tuberculosis: Y N Unknown **Mental Illness**: Y N Unknown
Substance Abuse: Y N Unknown **Cardiovascular Disease**: Y N Unknown
Diabetes mellitus: Y N Unknown **Death before age 50**: Y N Unknown
High Blood Pressure: Y N Unknown

Diet & Intake

Do you drink alcoholic beverages? _____ If yes, how many per week? _____

Do you drink caffeinated beverages?_____ If yes, how many per week? _____

Do you smoke? _____ Use recreational drugs? _____

Have you struggled with addiction? _____

If yes, please explain

_____

_____

What do you eat in a typical day?

_____

_____

How much water do you drink? (Note bottles, ounces, glasses etc)

_____

Current Health Overview

Please underline any issues that are current or recent problems for you. You can use the line below to provide any explanations.

General: night sweats, fatigue/tiredness, weight issues, appetite changes, fever, temperature regulation

_____
_____
_____

Mental/Emotional: depression, anxiety, mood swings, nervousness, tension, phobias, suicidal thoughts, alcohol/drug dependency, obsessive thoughts, hallucinations, voices, lack of mental focus, negative self-talk, other

_____
_____
_____

Skin: rash, infection, growths/bumps, nail problems, thinning/sensitive skin, other

_____
_____
_____

Endocrine: thyroid problems, diabetes, blood sugar problems, excessive thirst or hunger, weight gain, weight loss, sugar cravings, abnormal hair growth, excessive perspiration, temperature regulation problems, other

_____
_____
_____

Head: frequent headaches, migraines, head injury, light-headedness, hair loss/thinning, other

_____
_____
_____

Eyes/Ears/Nose/Sinus:: vision problems, eye pain, double vision, itchy/watery eyes, hearing loss, ringing, earache, dizziness, itchy ears, hearing aids, frequent colds, nose-bleeds, sinus infections, hay fever/allergies, loss of smell, snoring, other

_____
_____
_____

Mouth/Throat/Neck: sore throat/hoarseness, sore tongue, mouth sores, phlegm, swollen glands, enlarged thyroid, trouble swallowing, neck pain, other

_____

_____
_____

Musculoskeletal: joint pain/stiffness, muscle cramps/spasms, weakness, other

_____
_____
_____

Heart/Circulatory: chest pain or discomfort, high blood pressure, heart murmur, palpitations, ankle swelling, dizziness, varicose veins, cold extremities, other

_____
_____
_____

Respiratory: cough, sputum, wheezing, chest pain, shortness of breath, other

_____
_____
_____

Digestion: heartburn, abdominal pain, nausea/vomiting, black tarry stools, abdominal bloating, belching/gas, hemorrhoids, constipation, diarrhea, other

_____
_____
_____

Urinary: pain with urination, urgency/frequency, incontinence, frequent bladder infections, blood in urine, genital sores/discharge, other

_____
_____
_____

Testicular Reproduction: erectile difficulties, scrotal swelling/inflammation, blood in ejaculate, other

_____
_____
_____

Uterine Reproduction: excessive menstrual bleeding/pain/clots, irregular bleeding, vaginal discharge/itching/sores, painful intercourse, breast pain/lumps, nipple discharge, recurrent yeast infections, lack of sex drive, PMS, bloating, irritability, tearfulness, hot flashes, vaginal dryness, other

_____

_____

Have you ever lived near a refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

_____

Do you spray pesticides, herbicides or other chemicals around your home?_____

Insurance Information

Name of Insurance company:_____
Phone Number of Insurance Company:_____
ID #:_____