Intake Form

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Please Note. This detailed intake form has many questions that may or may not pertain to your condition. These questions are searching for potentially undiagnosed conditions and connections between ailments. Please feel free to answer only those questions you feel are important towards your health concerns, or take the time to finish the full form.

Any questions that you would rather discuss in person can be marked-off for future discussion.

Name_____ Today's date_____
Address_____
Phone: Home_____ cell_____
Email_____
Date of birth_____ Age_____ Male/Female/Other
Height_____ Weight_____
Relationship status_____ Children_____
Occupation_____
Main Reason for visit (diagnoses, main complaints and symptoms)

Other health issues

Hobbies, skills, interests, favorite pastimes

Exercise-what type of daily, weekly or monthly exercise do you practice

Practitioners

Are you currently under the care of a health care practitioner? Please note which of the following types of health care practitioners you have seen. Use '**P**' if you have seen them in the past and '**C**' if you are currently under their care.

____Ayurvedic practitioner	____Naturopath	____Psychiatrist	____Medical doctor (type)_____
____Chiropractor	____Social Worker	____Psychologist	____Bodywork (type) _____
____Counseling	____Massage therapist	____Spiritual counselor	Other_____
____Herbalist	____Occupational therapist	____Traditional Chinese Medicine	
____Homeopath	____Physical therapist		

Western medical diagnosis known (please include any significant lab reports)

Other diagnosis

Current medications and treatments

Previous medications and treatments

Health History

Please check any of the below symptoms or diseases you have experienced. Use a scale of 1-5, **1** the least and, **5** being the most severe. If unsure, use a question mark '**?**'.

____AD(H)D	____Epilepsy	____Male health problems
____AIDS	____Epstein-Barr virus	____Memory lose
____Alcoholism	____Excess stress	____Menopause problems
____Allergies	____Eyesight problems	____Menstrual irregularities
____Anemia	____Fatigue	____Numbness
____Anxiety	____Gynecological problems	____Painful joints
____Arthritis	____Headaches	____Rashes
____Asthma	____Hearing problems	____Respiratory problems
____Bloating	____Heart disease	____Seizures
____Cancer	____Hepatitis A	____Shingles
____Chemical sensitivities	____Hepatitis B	____Shortness of breath
____Chronic fatigue	____Hepatitis C	____Sleep problems
____Common cold	____High blood pressure	____Sore throats
____Constipation	____HIV	____Stiffness
____Diabetes	____Hyperglycemia	____Stomach aches
____Diarrhea	____Hypoglycemia	____Swelling
____Dizziness	____Immune disorders	____Tumors
____Drug abuse	____Injuries	____Urinary tract infections
____Environmental sensitivities	____Low blood pressure	Other_____

Immune System

Please mark '**P**' for previous condition, '**C**' for current and '**?**' if unsure.

____Adenitis	____Graves disease	____Lowered resistance	____Sick often
____Allergies	____Hashimoto's thyroiditis	____Lupus (SLE)	____Sore throats
____Autoimmune disorders	____Heal slowly	____Mononucleosis	____Swollen lymph glands
____Catch everything	____Immunodeficiency	____Myasthenia gravis	____White blood cell count
____Chronic fatigue	____Infections	____Pernicious anemia	
____Enlarged spleen	____Low grade fever	____Rheumatoid arthritis	Other_____

Do you have any concerns about your immune system?

Childhood diseases and syndromes

____Allergies	____Chicken pox	____Mononucleosis	____Whooping cough (Pertussis)
____Asthma	____German measles (Rubella)	____Mumps	
____Atopic eczema		____Rheumatic fever	Other_____
____Bronchitis	____Measles	____Tonsillitis	

Skin

Mark any of the conditions below that pertain to you. Use '**P**' for past problem and '**C**' for current.

____Acne	____Impetigo	____Scars
____Boils	____Itchy	____Sensitive to chemicals
____Bruise easily	____Moles	____Skin tags
____Dry hair	____Oily hair	____Slow to heal
____Dry skin	____Oily skin	____Varicose veins
____Eczema/psoriasis	____Pimples	Other_____
____Hair loss	____Rashes	

Energy levels

Are you satisfied with your energy levels, please describe

When is the high point and low point of your daily energy levels?

Have your energy levels changed markedly at any point recently or in your past. What preceded this change?

Hospitalization

Name any circumstances in which you were hospitalized and why (list approximate date and duration of stay)

What was your treatment, were there any follow-ups?

Which immunizations and vaccines have you received?

Please list any surgeries you've had along with approximate dates and reasons for them

Injuries

What serious injuries have you had?

What therapies and/or drugs did you take for them?

Have you ever been in an automobile or other serious accidents?

Have you ever injured your spine or back?

Family History

Has anyone in your immediate family had any of the following

____Cancer	____High blood pressure	_____Diabetes
____Heart disease	____Low blood pressure	Other_____

Drug History

Please list any previous medical or recreational drugs you have used in your past

Allergies

Do you have any allergies, what are they?

Which medicines (including herbal) have you taken for them?

When and where are your allergies least and most troublesome?

Do you have allergic reactions to any drugs or herbal medicines?

What has most helped your allergies?

Diet

Please fill in the below chart using the following scale

F –Frequently consume (daily or more)
O– Occasionally consume (a few times a week)
I – Irregularly consume, generally less than once a week
D – Do not consume this

____Alcohol	____Eat out	____Juice	____Seaweed
____Baked goods	____Eggs	____Milk	____Soda
____Beef	____Fast food	____Nut butters	____Sweets
____Beer	____Fermented foods	____Nuts/seeds	____Tea
____Black tea	____Fish	____Organic foods	____Vegetables cooked
____Bread	____Fried foods	____Pork	____Vegetables raw
____Cheese	____Fruit	____Potato chips	____Water
____Chicken	____Grains	____Refined flour	____Wine
____Cigarettes	____Green tea	____Refined sugar	
____Coffee	____Herbal tea	____Seafood	

Special diets; current and/or previous

Digestion

Please use '**P**' for previously, '**C**' for currently or '**?**' for unsure.

____Anorexia nervosa	____Dysentery	____Irritable bowel	____Stomach aches
____Belching	____Eating disorders	syndrome	____Sudden weight
____Bulimia	____Flatulence	____Large appetite	change
____Changes in bowel	____Food unappetizing	____Liver problems	____Ulcer
habits	____Gallstones	____Low appetite	____Ulcerative colitis
____Crohn's disease	____Giardia	____Nausea	____Vomiting
____Constipation	____Heartburn	____Pain after eating	Other_____
____Diarrhea	____Hemorrhoids	____Parasites	
____Diverticulitis	____Indigestion	____Shigella	

What are your favorite and least favorite foods?

What did you have for breakfast, lunch and dinner yesterday?

Using a scale of **1** (least favorite) to **5** (favorite) mark the following tastes and spices

____Bitter	____Fatty	____Pungent	____Spicy
____Cold (temperature)	____Hot (temperature)	____Salty	____Sweet
____Dry texture	____Moist texture	____Sour	Other_____

Body Temperature

Please write '**H**' for Hot and '**C**' for Cold, if applicable to these body areas

____General body	____Palms	____Feet	____Chest
____Arms	____Fingers	____Genital region	____Stomach
____Hands	____Legs	____Head	Other_____

Using a scale of **1** (least favorite/strong aversion) to **5** (favorite) check off these weather conditions

____Hot	____Cold	____Damp	____Humid
____Very hot	____Very cold	____Dry	

What is your favorite temperature range?
What part of the day are you warmest and coldest?

Emotional

Use a scale of **1** (rare) to **5** (very common) on the below conditions that are pertinent to you

____Angry	____Dreamy	____Happy	____Sad
____Anxious	____Enthusiastic	____Inspired	____Think a lot
____Attentive	____Fearful	____Lethargic	____Worry
____Bi-polar	____Forgetful	____Manic	Other_____
____Depressed	____Grumpy	____Nervous	

Memory

How is your long-term and short-term memory?

Has your memory changed noticeably in the past few years?

Eyesight

Are you near or far-sighted, do you wear corrective lenses?
Does the prescription for these change often?

Ears

Have you previously had '**P**' or currently have '**C**'

____Ear infections	____Overly sensitive	Other_____
____Earaches	____Tinnitus/Ringing	
____Hearing loss	____Wax build-up	

How is your hearing, has it changed in the past years?

Mouth & Throat

Please list '**P**' for previous or '**C**' for current conditions

____Cavities	____Excess saliva	____Oral herpes	____Swollen glands
____Constant dryness	____Lip sores	____Painful/tight jaw	____Swollen tongue
____Difficultly swallowing	____Loose teeth	____Sore gums	Other_____
	____Mouth sores	____Sore throats	

Headaches

Do you ever have headaches, how often. How long have you had them?
Location/type of headaches

____After eating	____Back of head	___Constant	____Morning
____Afternoon	____Band around head	____Dull	____Night
____Around eyes		____Evening	____Pounding
____Around temples	____Before eating	____Front of head	____Pre-mensis
____Aversion to stimuli	____Chronic	____Left side	____Right side
	____Cluster	____Migraine	Other_____

What triggers them

Are they seasonal? If so, which season?

Other symptoms associated with the headache (i.e., stomach pain)
Are they more or less often than in the past?

Does the severity or intensity vary from episode to episode?

What medicines and treatments have you tried, which were most successful?

Urinary Tract

Please mark '**P**' for previous and '**C**' for current for any of the below conditions

____Bloating	____Kidney/bladder stones	____Urinary tract infections
____Blood in urine	____Kidney pain	
____Burning urination	____Lower back pain	____Water retention
____Frequent urge to urinate	____Strong smelling urine	Other_____

Approximately how many times a day do you urinate?
Do you wake up at night to urinate, how many times?
Is it ever difficult to urinate?
Does you need to urinate ever seem urgent?
Have you had urinary tract infections? How often? How did you treat them?

After urinating, does it ever feel like you still have urine in your bladder?

Bowel Movements

How many times a day do you defecate?
Is it ever difficult to defecate? Do you strain to defecate?
Do your feces tend toward loose (soft) or hard?
Are you ever constipated, how often?

Do you ever have diarrhea (very loose stools)?

Is your need to defecate urgent?
Does it ever hurt to defecate?
Are your stools often very strong smelling?

Other bowel problems or symptoms?

Reproductive – Male and Female

Have you had any of the following. Write '**P**' for previously '**C**' for currently, '**S**' if you suspect you may have or '**?**' if you have a question about it.

____AIDS	____Genital warts	____Syphilis
____Candida	____Gonorrhea	____STDs
____Chlamydia	____HIV	____Trichomonas
____Crabs/lice	____Human Papilloma Virus	____Urethritis
____Gardnerella	(HPV)	Other_____

Please list any herbs or drugs you have used as treatment for the above

Reproductive – Male

Have you had any of the following symptoms or conditions. Use '**P**' for previously and '**C**' for currently or '**?**' if unsure.

____Benign Prostatic Hyperplasia (BPH)	____Excessive sexual thoughts	____Painful ejaculation
____Blood in semen	____Frequent urination	____Painful to urinate
____Blood in urine	____Impotence	____Penis pain
____Difficulty getting urine flowing	____Interrupted flow of urine	____Prostate pain
____Dribbling	____Libido low	____Testicle pain
____Erectile dysfunction	____Orchitis	____Vitality low
		Other_____

Do you get up at night to urinate, how often?

Does your prostate region ever hurt? If yes, is pain dull, constant, throbbing or sharp?

Is it ever painful to urinate – describe the pain

Does the urge to urinate interfere with your daily activities?

Do you have any problems getting and/or maintaining an erection?

Do you have any health concerns about your sexuality or vitality?

Reproductive – Female

Use '**P**' for past condition, '**C**' for current, '**S**' for unsure or '**?**' for any questions.

General

____Breast pain	____Miscarriage	____Unusual PAP
____Cervical dysplasia	____Painful intercourse	____Vaginal discharge
____Cysts	____Pelvic inflammatory disease (PID)	____Vaginal dryness
____Endometriosis		____Vaginal infection
____Fibroids	____STDs	_____Vaginitis
____Infertility	____Tumors	Other_____

Menstrual Cycle

____Acne
____Bleeding between cycles
____Mood swings
____Bloating (hands, stomach)
____Bloating (feet, hands, ankles)
____Irregular cycle
____Painful mensis
Other_____

Average number of days bleeding
Approximately how many days between mensis, is it regular or irregular?

Menstrual Blood

____Bright red
____Clots
____Dark colored
____Heavy flow
____Profuse flow
____Red
____Red brown
____Scanty flow
____Slow flowing
Other_____

Menopause

Are you currently in pre, peri or post menopause

____Dry vaginal mucosa
____Hormone replacement therapy
____Hot flashes
____Mood swings
____Night sweats
____Osteoporosis
____Sore muscles
Other_____

Contraception Method

____Birth control pills
____IUD
____Diaphragm
Other_____

Sleep Patterns

On a scale from **1** (rarely) to **5** (very often) mark the conditions pertinent to you.

____Fall asleep fast
____Sleep through the night
____Hard to fall asleep, but stay asleep
____Hard to fall and stay asleep
____Wake often
____Wake up to urinate
____Restless sleep
____Restful sleep
____Hard to wake up
____Stay awake till 11:00pm
____Stay awake till 1:00am
____Stay awake till 3:00am
Other_____

Dreams (circle those that apply): active, lucid, anxious, nightmares, probing, pleasant, interesting, scary, other_____
Which are your favorite hours to sleep?
Generally, how many hours of sleep do you need to feel rested?
Do you feel rested when you wake in the morning?

Cardiovascular Health

Please check the below questions pertinent to your health

____Angina
____Arrythmias (irregular heartbeat)
____Arteriosclerosis
____Black and blue easily
____Bleed easily
____Capillary fragility
____Cardiac arrest
____Chest pains
____Congenital deformities
____Congestive heart failure
____Edema
____Fast heart beat (tachycardia)
____Heart attack (myocardial infarction)
____Heart flutter
____Heart irregularities
____Heart murmur
____High blood pressure
____Ischemia
____Low blood pressure
____Mitral valve prolapse
____Palpitation
____Pericarditis
____Poor circulation
____Rheumatic fever
____Slow heart beat (bradycardia)
____Stroke
____Varicose veins
Other_____

Resting pulse rate_____ Blood pressure (avg)_____
Cholesterol (if know, LDL, HDL and total cholesterol)

Does your family have a history of heart conditions, what are they?

What are some of your other blood pressure readings over the past 3 years?

What drugs, herbal medicines or other treatments have you used?

Nervous System and Stress

Please mark with '**P**' for previously and '**C**' currently to any conditions that are pertinent to you. Please also follow a scale of **1** (noticeable but not a big problem) to **5** (major problem).

____Anxiousness
____Bipolar
____Butterflies in stomach
____Cannot stay asleep
____Constant feeling of stress
____Diminished taste
____Depression
____Fear of facing a new day
____Fluctuating vision
____Hard to concentrate
____Involuntary spasms
____Mania
____Memory loss
____Nervousness
____Numbness
____Pain – constant
____Panic attacks
____Seasonal affective disorder
____Sudden mood swings
____Trouble falling asleep
____Twitching
____Worsening coordination
Other_____

Describe your stress levels, what goes wrong with your body when stress levels are elevated

Respiratory

Please mark with a '**P**' for previously a problem, '**C**' for currently so, and '**?**' if unsure.

____Asthma
____Bronchitis
____Chest pain
____Common cold
____Coughing
____Difficulty smelling
____Flu (influenza)
____Fluid in lungs
____Hay fever
____Laryngitis
____Pleuritis
____Respiratory inflammation
____Runny nose
____Shortness of breath
____Sneezing
____Stuffy nose
____Tight around lungs
____Trouble breathing in
____Trouble breathing out
____ Wheezing
____Tuberculosis
Other_____

Do you have much congestion, which season is it worse and best? What helps it?

Mucous- quality and/or color

____Clear
____Green
____Yellow
____Thick/sticky
____Thin/runny
____Worse in the morning, afternoon, evening, night (circle)

Have you identified foods, environmental factors or situations that worsen your breathing. What are they?

Cough – check the symptoms which pertain to you

____Bloody
____Dry cough
____Hacking
____Itchy throat
____Painful
____Persistent
____Regularly
____Wet cough
____Worse at morning, afternoon, evening, night (circle)
____Triggers

Are their any other concerns you wish to share? Please use the back of this page to write anything else you feel may be important