**PATIENT NAME:** _____
**DATE OF BIRTH:** ____/____/_____

# PATIENT INFORMATION FORM
(PLEASE PRINT)

DATE: ___/___/___

PATIENT NAME: _____ _____ ___ DATE OF BIRTH: ___/___/___ AGE: ___ SEX: M F
LAST FIRST MI

HOME ADDRESS: _____ CITY/STATE: _____ ZIP: _____

MAY WE LEAVE A MESSAGE?

HOME PHONE #: (___) ___-_____ YES NO
WORK PHONE #: (___) ___-_____ YES NO
CELL PHONE #: (___) ___-_____ YES NO
E-MAIL: _____ YES NO

PRIMARY LANGUAGE: _____

DO YOU HAVE A LEGAL GUARDIAN OR HEALTHCARE POWER OF ATTORNEY? YES NO
IF YES, NAME: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

EMERGENCY CONTACT: _____ RELATIONSHIP: _____ PHONE #: (___) ___-_____

PRIMARY CARE DOCTOR: _____ WHO REFERRED YOU TO US? _____

PHARMACY: _____ LOCATION: _____ PHONE #: (___) ___-_____

IS THERE A FAMILY MEMBER OR OTHER PERSON YOU WOULD LIKE FOR US TO SHARE YOUR MEDICAL INFORMATION?
_____ YES NAME(S) _____
_____ NO

WHO IS RESPONSIBLE FOR PAYMENT? _____ RELATIONSHIP TO PATIENT? _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

## INSURANCE INFORMATION

PRIMARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

SECONDARY INSURANCE COMPANY NAME: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____ PHONE #: (___) ___-_____

INSURED NAME: _____ DATE OF BIRTH _____ EMPLOYER _____

CONTRACT # _____ GROUP # _____

# PATIENT INTAKE FORM

Name _____ Date _____

**NOW:** ☐ **PREGNANT** ☐ **PACEMAKER** ☐ **AIDS** ☐ **HEPATITIS** ☐ **BLOOD TRANSFUSION**

**FAMILY HISTORY:**

☐ Abuse ☐ AIDS ☐ Alcoholism ☐ Allergies ☐ Asthma ☐ Cancer ☐ Diabetes
☐ Drugs ☐ Heart Disease ☐ High Blood Pressure ☐ Respiratory Diseases ☐ Seizures
☐ Stroke ☐ Other _____

**YOUR PAST MEDICAL HISTORY/ILLNESSES:**

☐ Aids ☐ Alcoholism ☐ Arthritis ☐ Asthma ☐ Auto Immune Disease ☐ Bronchitis ☐ Cancer
☐ Chronic Fatigue Syndrome ☐ Chronic Lung Disease ☐ Diabetes ☐ Drugs ☐ Heart Disease
☐ Hepatitis ☐ Hernia ☐ High Blood Pressure ☐ Kidney Disease ☐ Organ Transplant ☐ Pneumonia
☐ Rheumatic Fever ☐ Seizures/Epilepsy ☐ Sexually Transmitted Diseases (STD)_____
☐ Thyroid Disease ☐ Tuberculosis ☐ Ulcers ☐ Vaccine Reaction ☐ Whooping Cough

**SURGERIES: (Please include dates)**

1. _____
2. _____
3. _____

**TRAUMATIC INJURY: (Please include dates)**

Car accident _____
Falls _____
Other _____

**ALLERGIES:**

Drugs _____
Chemicals _____
Food _____
Others _____

**CURRENT MEDICATIONS:**

**OCCUPATIONAL/ENVIRONMENTAL EXPOSURES OR HAZARDS:**

Chemical: _____ Acid/Alkalines: _____
Heavy Metals: _____ Physical Labor: _____
Electrical: _____ Psychological: _____

**HABITS/EXCESSIVE USAGE:**

☐ alcohol ☐ chocolate ☐ cigarettes ☐ coffee ☐ cola ☐ drugs ☐ exercise ☐ food ☐ salt
☐ sex ☐ sugar ☐ tea ☐ other _____

**CHIEF COMPLAINT / REASON FOR COMING IN:** _____

_____

## GENERAL

- ☐ poor appetite
- ☐ change in appetite
- ☐ large appetite
- ☐ cravings
- ☐ weight gain
- ☐ weight loss
- ☐ fevers
- ☐ chills
- ☐ sweating
- ☐ night sweats
- ☐ sweats easily
- ☐ headache
- ☐ insomnia
- ☐ hours of sleep _____
- ☐ easy to fall asleep
- ☐ heavy sleeper
- ☐ light sleeper
- ☐ dream disturbance
- ☐ hard to fall back asleep
- ☐ tremors/shaking
- ☐ dizziness
- ☐ poor coordination
- ☐ vertigo
- ☐ edema
- ☐ bleeds easily
- ☐ bruises easily
- ☐ fatigue/tired
- ☐ sudden drop in energy

***Are you taking:***

- ☐ Aspirin
- ☐ Blood Thinners
- ☐ Vitamins
- ☐ Herbs
- ☐ Supplements

***Energy level***: ☐ high ☐ moderate ☐ low

***Thirsty, desires***: ☐ hot ☐ cold ☐ room temp. ☐ no desire

***Coldness***: ☐ hands ☐ feet ☐ back

***Heat***: ☐ hands ☐ feet ☐ solar plexus ☐ abdomen ☐ whole body

***Stiffness***: ☐ joints ☐ back ☐ limbs

***Intolerance to***: ☐ hot ☐ cold ☐ wind ☐ fan ☐ A/C

***Pain***: ☐ upper back ☐ lower back ☐ upper limbs ☐ lower limbs ☐ whole body

***Rate the pain***: Scale 1-10 (10 worst) _____

## SKIN AND HAIR

- ☐ rashes
- ☐ eczema

***skin***: ☐ dry ☐ moist

- ☐ sores
- ☐ ulcers
- ☐ herpes
- ☐ psoriasis
- ☐ eruptions
- ☐ discharge
- ☐ pimples/acne
- ☐ bruises
- ☐ hives
- ☐ itching
- ☐ sweating
- ☐ change in skin texture
- ☐ dandruff
- ☐ loss of hair
- ☐ balding
- ☐ thinning of hair
- ☐ change in hair
- ☐ other hair problems: _____
- ☐ other skin problems: _____

## HEAD, EYES, EARS, NOSE, MOUTH & THROAT

**Head**

- ☐ dizziness
- ☐ migraine

***Headaches***:

- ☐ frontal
- ☐ temporal
- ☐ vertex
- ☐ occipital

- ☐ head injury
- ☐ facial pain
- ☐ facial paralysis
- ☐ sinus problems

other:_____

**Eyes (R/L)**

- ☐ cataract/ glaucoma
- ☐ eye pain
- ☐ twitching
- ☐ floaters/spots
- ☐ poor vision
- ☐ blurry vision
- ☐ night blindness
- ☐ itchiness
- ☐ glasses/contacts
- ☐ red eyes

other:_____

**Ears (R/L)**

- ☐ loss of hearing
- ☐ discharge
- ☐ earaches
- ☐ poor hearing
- ☐ itchiness

***Ringing in ears***:

- ☐ loud ☐ soft
- ☐ high pitch
- ☐ low pitch

- ☐ inflammation
- ☐ tenderness

other:_____

**Nose**

- ☐ loss of smell
- ☐ good sense of smell
- ☐ nose bleeds
- ☐ allergies
- ☐ nasal discharge

***color***: ☐ yellow ☐ white ☐ clear ☐ green

***amount***: ☐ scanty ☐ mod ☐ heavy ☐ thick ☐ thin

other:_____

**Mouth**

- ☐ grind teeth
- ☐ drooling
- ☐ excess saliva
- ☐ dry mouth
- ☐ gum disease
- ☐ bad breath
- ☐ gum bleeding
- ☐ gum swelling
- ☐ taste in mouth
- ☐ ulcers
- ☐ sores

other:_____

**Throat**

- ☐ dry throat
- ☐ hoarseness
- ☐ recurrent sore throat
- ☐ loss of voice
- ☐ difficulty swallowing
- ☐ lump in throat
- ☐ frequent tonsilitis

other:_____

## CARDIOVASCULAR

- ☐ high blood pressure
- ☐ low blood pressure
- ☐ dizziness
- ☐ fainting
- ☐ palpitations
- ☐ chest pain
- ☐ cold hands/feet
- ☐ swelling hands/feet
- ☐ irregular heart beat
- ☐ insomnia
- ☐ difficulty in breathing
- ☐ shortness of breath
- ☐ dream disturbance
- ☐ poor memory
- ☐ mania/delirium
- ☐ coma
- ☐ loss of consciousness

other:_____

## RESPIRATORY

- ☐ pneumonia
- ☐ bronchitis
- ☐ asthma
- ☐ coughing blood
- ☐ wheezing

***cough***: how long? _____

☐ dry ☐ croup ☐ rapid ☐ other

***phlegm***: ☐ thin ☐ thick ☐ clear ☐ white ☐ yellow ☐ green

- ☐ tightness in chest
- ☐ shortness of breath
- ☐ fullness in chest

***difficulty breathing***: ☐ sitting ☐ lying down

- ☐ other chest discomfort

## GASTROINTESTINAL

| | | | | |
|---|---|---|---|---|
| ☐ food allergies | ☐ taste in mouth | ☐ loose stools | ☐ difficult stools | ☐ tenderness in abdomen |
| ☐ vomiting | ☐ belching | ☐ bloody/black stools | ☐ mucus in stools | ☐ fullness in abdomen |
| ☐ cramping | ☐ bad breath | ☐ ulcers | ☐ hemorrhoids | ☐ burning in abdomen |
| ☐ gas | ☐ hiccup | ☐ increased appetite | ☐ hernia | ☐ like/dislike pressure |
| ☐ abd/stomach pain | ☐ constipation | ☐ poor appetite | ☐ rectal pain | ☐ like/dislike cold |
| ☐ nausea | ☐ diarrhea | ☐ hungry-no desire to eat | ☐ rectal bleeding | ☐ like/dislike warmth |

## GENITO-URINARY

| | | | |
|---|---|---|---|
| ☐ burning /painful urine | ☐ poor stream/scanty urine | ☐ diminished sex drive | ☐ discharge |
| ***color***: ☐ cloudy ☐ pale | ☐ dribbling urine | ☐ increased sex drive | ☐ history of kidney stones |
| ☐ dk yellow ☐ pink/red | ☐ unable to urinate | ☐ impotency | ☐ history of bladder infections |
| ☐ unable to hold urine | ☐ frequent urination | ☐ genital itching | ☐ history of prostate problems |
| ☐ wakes up to urinate | ☐ urgency to urinate | ☐ genital sores/pain | ☐ history of STD |

## MUSCULO-SKELETAL

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| ☐ joint pain | ***upper limbs***: | ☐ pain | ☐ swelling | ☐ burning | ☐ weakness | ☐ numbness | ☐ tingling |
| | | ☐ tenderness | | ☐ stiffness | | | |
| ☐ joint swelling | ***lower limbs***: | ☐ pain | ☐ swelling | ☐ burning | ☐ weakness | ☐ numbness | ☐ tingling |
| | | ☐ tenderness | | ☐ stiffness | | | |
| ☐ joint stiffness | ***back***: | ☐ pain | ☐ swelling | ☐ burning | ☐ weakness | ☐ numbness | ☐ tingling |
| | | ☐ tenderness | | ☐ stiffness | | | |
| ☐ sciatica | ***neck***: | ☐ pain | ☐ swelling | ☐ burning | ☐ weakness | ☐ numbness | ☐ tingling |
| | | ☐ tenderness | | ☐ stiffness | | | |

## NEUROPHYSIOLOGICAL

| | | | |
|---|---|---|---|
| ☐ history of emotional problems | ☐ melancholy | ☐ joyful | ☐ tremors/shaking |
| ☐ depression | ☐ grieving | ☐ giddy | ☐ convulsions |
| ☐ anxiety | ☐ easy to anger | ☐ over-thinking | ☐ coma |
| ☐ easily stressed | ☐ irritability | ☐ talkative | ☐ concussion |
| ☐ confusion/foggy | ☐ restlessness | ☐ silent | ☐ paralysis |
| ☐ lack of clarity | ☐ emotional | ☐ extrovert | ☐ trauma at birth |
| ☐ moody | ☐ frequent sighing | ☐ introvert | ☐ vaginal delivery ☐ cesarean |
| ☐ fear/fright | ☐ over-worried | ☐ poor memory | ☐ considered/attempted suicide |
| ☐ hyper | ☐ bad-tempered | ☐ seizures | ☐ unable to focus |
| | | | ☐ phobia_____ |

## GYNECOLOGY AND PREGNANCY [Last Menstrual Period_____ Last PAP _____ ]

| | | | |
|---|---|---|---|
| ☐ no. of pregnancies ___ | ☐ age at first menses _____ | ☐ fibroids | ***color***: ☐ lt. red ☐ red |
| ☐ no. of live births_____ | ☐ length of period _____ | ☐ abd. Bloating/fullness | ☐ dk red ☐ dk purple |
| ☐ no. of miscarriages___ | ☐ number of days in cycle __ | ☐ pain with stools | ***clots***: ☐ large ☐ small |
| ☐ no. of premature births _____ | ☐ early menstrual cycle (less than 21 days) | ☐ mood change before period | ***vaginal discharge***: |
| | | ☐ body change before period | ☐ odor ☐ no odor |
| ☐ no. of abortions _____ | ☐ late menstrual cycle | ***menstrual pain/cramps***: | ☐ watery ☐ thick |
| ☐ infertility | (less than 35 days) | ☐ before ☐ during ☐ after | ☐ curdy ☐ itchy |
| ☐ pain during intercourse | ☐ irregular menstrual cycle | ☐ days of heavy flow_____ | ***color***: ☐ clear ☐ white |
| ☐ uterine prolapse | ☐ ***menopause***: ☐ pre ☐ post | ☐ endometriosis | ☐ yellow ☐ bloody |
| ***birth control pills***: | ☐ age at menopause _____ | ***flow***: ☐ thick ☐ thin | ☐ vaginal burning/itching |
| type _____ | ☐ history of ovarian cysts | ***amount***: ☐ scanty ☐ mod | ☐ vaginal pain |
| how long? _____ | ☐ history of uterine problems | ☐ heavy ☐ very heavy | ☐ vaginal sores |

## BREAST

| | | |
|---|---|---|
| ☐ history of breast disease | ☐ breast tenderness | ***breast discharge***: ☐ clear ☐ white ☐ yellow ☐ green |
| ☐ breast lumps/masses | ☐ breast fullness/swelling | ☐ black ☐ blood ☐ watery ☐ thin ☐ thick |
| ☐ history of breast cancer | ☐ breast pain | other:_____ |