PATIENT INTAKE FORM

Name: _____
(Surname) *(First)* *(Initial)*

Date of birth: _____ Gender: □ Male □ Female
(day/month/year)

Occupation: _____

Contact Information:
**** Please inform the clinic if your contact information changes****

Address: _____
(Street and number) *(City)* *(Postal Code)*

Phone: _____
(Daytime) *(Evening)* *(Fax)*

Email: _____

Emergency contact: _____
(Name) *(Relationship)*

_____
(Daytime phone number) *(Evening phone number)*

How did you hear about our clinic? _____

Your Health Care Providers:
Who is your primary
care physician ? _____
(Name) *(Phone Number)*

When was your last
physical exam? _____
(Month) *(Year)*

Are you currently under the care of a specialist?

1) _____
(Name) *(Phone Number)*

2) _____
(*Name)* *(Phone Number)*

Are you currently under the care of an alternative healthcare provider (e.g., acupuncturist, chiropractor, registered massage therapist)?

1) _____
(Name) *(Phone Number)*

2) _____
(Name) *(Phone Number)*

HEALTH CONCERNS;

Please list any health concerns in order of importance:

1)
(Describe your condition)

When did it start? _____

Has this condition been diagnosed? Yes No _____

2)
(Describe your condition)

When did it start? _____

Has this condition been diagnosed? Yes No _____

3)
(Describe your condition)

When did it start? _____

Has this condition been diagnosed? Yes No _____

4)
(Describe your condition)

When did it start? _____

Has this condition been diagnosed? Yes No _____

5)
(Describe your condition)

When did it start?

Has this condition been diagnosed? Yes No _____

MEDICATIONS

What medications are you currently taking? Your list should include: **prescription** and **over-the-counter drugs; birth control pills, herbal remedies, vitamins** and **other supplements.**

Pharmaceutical drug or supplement (for supplements, please include the brand)	How much do you take per day?	Why are you taking the medications?

Have you ever used or been treated with any of the following?
(Please check the following)

- ▫ Antibiotics for more than 2 week
- ▫ Cortisone or other steroids
- ▫ Antihistamines
- ▫ Drugs for arthritis (Vioxx, Celebrex)
- ▫ Thyroid Medications
- ▫ Laxatives or stool softeners
- ▫ Anti-depressants
- ▫ Flu vaccinations
- ▫ Vaccinations for foreign travel
- ▫ Sleeping pills or sedative
- ▫ Antacids
- ▫ Chemotherapy/radiation
- ▫ Pain relievers (aspirin, ibuprofen)
- ▫ Hormone therapy (including fertility treatments)
- ▫ Recreational drugs
- ▫ Blood thinners
- ▫ Stimulants
- ▫ Diuretics

Adverse reactions to medications: Please describe any adverse reactions you had to

- Prescription drugs, over-the-counter drugs or recreational drugs
- Vaccinations (childhood, travel, flu, hepatitis)
- Natural medicines (herbs, vitamins, minerals, homeopathics)

Name of drug, vaccine or natural medicine	Describe the reaction
1)	
2)	
3)	

MEDICAL HISTORY

Please list any allergies or sensitivities (***food, pollen, mold, minerals, chemicals***) you suffer from or have previously experienced.

Allergy	Age of onset

Please list surgeries and/or hospitalizations you have had.

Reason/Procedure	Year	Outcome

Do you frequently use any of the following? (Please check if indicated)

- ▫ Alcohol – how much/day or week

  _____

- ▫ Tobacco- form and amount/day

  _____

- ▫ Caffeine- form and amount/day

  _____

- ▫ Recreational drugs- what and how often

  _____

Do you get regular screening tests done by another doctor? (Pap, blood tests etc)? Yes/No

Do you have any dietary restrictions? (vegetarians, religious, allergies) Yes/No
If yes, please state them _____

ENVIRONMENT

Toxin Exposure

Have you ever been exposed to mold, solvents, lead, paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations) at work or while traveling?	Y	N
Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide?	Y	N
Are you particularly sensitive to perfume, gasoline or other vapors?	Y	N
Have you ever lived near a refinery or a polluted area?	Y	N
Have you ever lived in a more than 50 years old?	Y	N

How would you describe the emotional climate of your home?

_____
_____
_____

How stress is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____

Do you exercise regularly? □ Yes □ No If yes, what do you do for exercise, how much, how often?

_____
_____
_____