PATIENT INTAKE FORM FOR THE PRACTITIONER

Patient Name: ____________________

Street: ____________________ City ____________________ State ________ Zip ________

Home Phone: ____________________ Work Phone: ____________________

Age: ________ Height: ________ Weight: ________ Date of Birth ____________________

Place of Birth: ____________________ Social Security Number: ____________________

Occupation: ____________________ Partner Status: ____________________

In Emergency Notify: ____________________

Referred by: ____________________

Family Physician: ____________________

Insurance Carrier: ____________________ Policy Number: ____________________

Date ____________________ Concurrent Health Therapies or Regimens: ____________________

FAMILY MEDICAL HISTORY

- ☐ Allergies
- ☐ Cancer
- ☐ Seizures
- ☐ Diabetes
- ☐ Stroke, Heart disease
- ☐ Alcoholism
- ☐ Asthma
- ☐ High blood pressure
- ☐ Other ____________

PAST MEDICAL HISTORY (WITH DATES)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma
- ☐ Vaccinations
- ☐ Childhood Illnesses
- ☐ Other significant illnesses
- ☐ Accidents or significant trauma
- ☐ Medications ____________

LIFESTYLE AND OCCUPATION

Exercise: ____________________

Dietary considerations: ____________________

Habitual consumptions: ☐ Cigarettes ☐ Coffee, tea or cola ☐ Alcoholic beverages ☐ Other

Occupational stress factors: ____________________

Medications taken within the last two months (vitamins, drugs, herbs, etc.): ____________________

CURRENT GENERAL HEALTH INDICATORS

- ☐ Poor appetite
- ☐ Disturbed sleep
- ☐ Fatigue
- ☐ Poor coordination
- ☐ Weight gain
- ☐ Cold hands
- ☐ Night Sweats
- ☐ Cold abdomen
- ☐ Tremors
- ☐ Heavy appetite
- ☐ Heavy sleep
- ☐ Localized weakness
- ☐ Strong thirst
- ☐ Weight loss
- ☐ Cold feet
- ☐ Fevers
- ☐ Poor balance
- ☐ Bleeding or bruising easily
- ☐ Changes in appetite
- ☐ Insomnia
- ☐ Sweating easily
- ☐ Cravings
- ☐ Change in appetite
- ☐ Cold back
- ☐ Chills
- ☐ Sensitive to tastes or smells
- ☐ Sudden energy drop (when?)
- ☐ Other unusual or abnormal conditions ____________________

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Purpura
- ☐ Ulcerations
- ☐ Eczema
- ☐ Hair loss
- ☐ Changes in hair or skin texture
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Any other hair or skin problems ____________________

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Advanced Wellness Centre

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Concussions
- ☐ Migraines
- ☐ Glasses
- ☐ Spots in front of eyes
- ☐ Headaches (where? when?)
- ☐ Eye pain
- ☐ Poor vision
- ☐ Night blindness
- ☐ Color blindness
- ☐ Cataracts
- ☐ Blurry vision
- ☐ Eyestrain
- ☐ Spots in eyes
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Earaches
- ☐ Mucus
- ☐ Dry throat
- ☐ Dry mouth
- ☐ Copious saliva
- ☐ Sinus problems
- ☐ Recurrent sore throats
- ☐ Nose bleeds
- ☐ Grinding teeth
- ☐ Sores on lips or tongue
- ☐ Facial pain
- ☐ Teeth problems
- ☐ Gum problems
- ☐ Jaw clicks
- ☐ Any other head or neck problems ______________________________

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Low blood pressure
- ☐ Chest pain
- ☐ Irregular heartbeat
- ☐ High blood pressure
- ☐ Fainting
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of feet
- ☐ Blood clots
- ☐ Difficulty in breathing
- ☐ Phlebitis
- ☐ Any other heart or blood vessel problems ______________________________

RESPIRATORY

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma ______
- ☐ Bronchitis
- ☐ Pain with deep inhalation
- ☐ Pneumonia ______
- ☐ Difficulty breathing when lying down ________
- ☐ Production of phlegm (color?) ____
- ☐ Any other lung problems ______________________________

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stools
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Abdominal pain or cramps
- ☐ Chronic laxative use
- ☐ Sensitive abdomen
- ☐ Any other GI problems ______________________________

GENITOURINARY

- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Urgency to urinate
- ☐ Unable to hold urine
- ☐ Kidney stones
- ☐ Decrease in flow
- ☐ Impotence
- ☐ Sores on genitals
- ☐ Waking at night to urinate
- ☐ Any particular color to urine
- ☐ Any other problems with genitourinary function ______________________________

REPRODUCTIVE AND GYNECOLOGIC

- Age at menarche ______
- Age at menopause ______
- Number of pregnancies ______
- Number of live births ______
- Premature births ______
- Miscarriages/abortions ______
- ☐ Menstrual clots
- ☐ Painful menses
- ☐ Irregular menses
- Length of cycle ______
- Duration of menses______
- ☐ Premenstrual changes
- ☐ Strong menstrual odor
- ☐ Other menstrual problems ______________________________
- ☐ Vaginal discharge
- ☐ Vaginal odor
- ☐ Breast lumps or swellings
- Birth control method (since _____)
- ☐ Other problems ______________________________

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Muscle pains
- ☐ Knee pain
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Foot/ankle pains
- ☐ Hand/wrist pains
- ☐ Shoulder pains
- ☐ Hip pain
- Any other joint or bone problems ______________________________

NEUROPSYCHOLOGICAL

- ☐ Seizures ________
- ☐ Dizziness ________
- ☐ Loss of balance ________
- ☐ Areas of numbness ________
- ☐ Poor memory ________
- ☐ Lack of coordination ______
- ☐ Concussion ________
- ☐ Depression ________
- ☐ Anxiety ________
- ☐ Bad temper ________
- ☐ Easily susceptible to stress
- ☐ Treated for emotional problems ______________________________
- ☐ Considered or attempted suicide ______________________________
- ☐ Any other neurological or psychological problems ______________________________