HOLISTIC CENTER FOR Vibrant Health
Your Partners in Creating a Dynamic Life

New Patient Intake Form

___ I understand that 24 hours is required to cancel any appointments, otherwise I will be charged a $30 cancellation/no show fee.

Name: _____ Date: _____

Address: _____ City: _____ State:_____ Zip:_____

Home Phone: _____ Cell Phone: _____

Email Address: _____ May we contact you via email? ___Yes ___No

Age: _____ Date of Birth: _____ SSN: _____ Marital Status: M S W D

Occupation: _____ Employer: _____

Work Phone: _____

Spouse's Name: _____ Phone: _____

Name of Nearest Relative: _____ Phone: _____

Names and Ages Of Children: _____

Family Medical Doctor: _____

How were you referred to our office?_____

History of Present Illness

Purpose of this Visit: _____ Wellness Checkup _____ Auto Accident _____Work Injury

Other: _____

When Did You First Notice This Problem: _____

How Did It Originally Occur: _____

How Has It Progressed Recently? _____ Same _____ Improving _____ Getting Worse

How Frequent Is This Condition? _____ Constant _____ Frequently _____Intermittent _____ Occasionally

Describe The Pain: ____ Sharp ____ Dull ____Numbness ____Tingling ____Aching ____Burning

What Makes The Pain Better: _____

What Makes The Pain Worse: _____

What Does This Problem Prevent You From Doing? _____

Please Rate Your Pain Level Below:

No Symptoms ←——————————————————→ Severe Symptoms

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Name:_____

Personal Medical History

Significant Illness

☐ Cancer
☐ Hepatitis
☐ HIV (AIDS)
☐ Allergies
☐ Asthma
☐ Seizures
☐ Heart Disease
☐ Weight Problems
☐ Tuberculosis
☐ Herpes
☐ Diabetes
☐ Thyroid Disease
☐ Venereal Disease
☐ Addictive Disorder
☐ High Blood Pressure
☐ Rheumatic Fever
☐ Stroke
☐ Mental Illness
☐ Other:
_____
_____

Please check if you experienced ANY of the following:

General

☐ Poor/Change in Appetite
☐ Fever(s)/Chills (***Circle One)***
☐ Sweat Easily
☐ Peculiar Taste/Smells (***Circle One)***
☐ Depression
☐ Bleeding
☐ Weight Gain /Loss
☐ Strong Thirst
☐ Poor Balance
☐ Tremors
☐ Night Sweats
☐ Changes in Energy/Fatigue
☐ Emotional Changes
☐ Bruising
☐ Joint Pain
☐ Hearing Loss
☐ Cravings
☐ Headaches/Migraines
☐ Localized Weakness
☐ Insomnia

Skin and Hair

☐ Rashes
☐ Eczema
☐ Recent Moles
☐ Itching
☐ Hair Loss
☐ Hives
☐ Change in Skin Texture
☐ Dandruff
☐ Change in Hair Texture
☐ Ulcers
☐ Acne
☐ Psoriasis

Head, Eyes, Ears, Nose and Throat

☐ Dizziness
☐ Concussions
☐ Jaw Click/TMJ
☐ Cataracts/Blurred Vision
☐ Night Blindness
☐ Nose Bleed
☐ Gum Problems
☐ Cough Blood
☐ Asthma/Wheezing (***Circle One)***
☐ Floaters/Spots (***Circle One)***
☐ Glasses / Poor Vision (***Circle One)***
☐ Grinding Teeth
☐ Sinus Problems
☐ Toothache
☐ Ringing in Ears
☐ Glaucoma
☐ Shortness of Breath
☐ Pain when Breathing
☐ Sore Throat
☐ Eye Strain/Pain
☐ Earaches
☐ Facial Pain
☐ Mouth Ulcers
☐ Color Blindness
☐ Cough
☐ Bronchitis
☐ Phlegm

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Cardiovascular

- ☐ Blood Clots
- ☐ Dizziness
- ☐ Hands/Feet Swell ***(Circle One)***
- ☐ Palpations
- ☐ Fainting
- ☐ Low/High Blood Pressure ***(circle one)***
- ☐ Irregular Heart Beat
- ☐ Difficulty Breathing/Short of Breath
- ☐ Chest Pain
- ☐ Cold Hands/Feet
- ☐ Cold Sweats
- ☐ Phlebitis

Gastrointestinal

- ☐ Nausea/Vomiting ***(circle one)***
- ☐ Belching/Gas ***(circle one)***
- ☐ Parasites
- ☐ Abdominal Pain/Ulcers ***(circle one)***
- ☐ Constipation/Diarrhea ***(circle one)***
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Bad Breath
- ☐ Blood in Stool
- ☐ Bloating

Genito-Urinary

- ☐ Painful Urination
- ☐ Blood in Urine
- ☐ Impotence
- ☐ Frequent Urination
- ☐ Incontinence/Urgency ***(circle one)***
- ☐ Kidney Stones
- ☐ Genital Sores
- ☐ Discolored Urine
- ☐ Decreased Urination

Gynecology & Pregnancy

- ☐ Irregular/Painful Cycles ***(circle one)***
- ☐ Age of First Cycle:
- ☐ Heavy/Light Flow ***(circle one)***
- ☐ Vaginal Discharge/Sores ***(circle one)***
- ☐ Fertility Problems
- ☐ # of Pregnancies:
- ☐ PMS
- ☐ Currently Pregnant Due:
- ☐ Clots
- ☐ Date of Last Cycle:
- ☐ Date of Last Exam:
- ☐ # of Births:

Neuro-Psychological

- ☐ Seizures
- ☐ Headache/Migraine
- ☐ Concussion
- ☐ Mood Swings/Easily Angered
- ☐ Lack of Coordination/Disoriented
- ☐ Stress
- ☐ Irritable
- ☐ Anxiety
- ☐ Depression
- ☐ Poor Memory
- ☐ Areas of Numbness
- ☐ Balance/Dizziness

Family History:

Check any conditions that run in your family and indicate if the family member is your **G**randparent, **F**ather, **M**other, **S**ister, or **B**rother.

___Diabetes ___Cancer ___Mental Illness ___Arthritis
___Stroke ___Asthma ___Kidney Disease ___Liver Disease
___Heart Disease ___Lung Disease ___Other: _____

2323 Curlew Road Suite 6C Dunedin, FL 34698 • 727-772-1966 (office) • 727-772-0096 (fax) •www.mydrlisa.com

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Name:_____

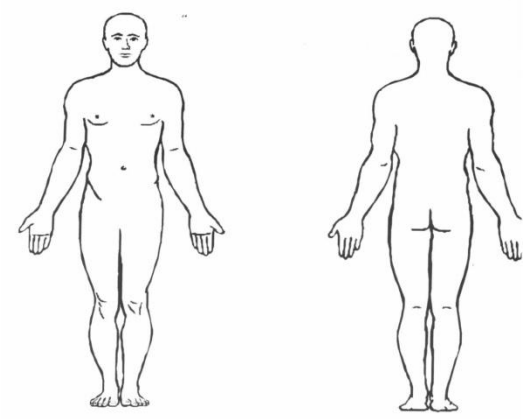
Social History

Please describe the frequency and type:

___ Alcohol _____
___Tobacco Products _____
___Caffeine _____
___Vitamins _____
___Exercise _____
___Hobbies _____

• What percentage of the day are you: ___lifting ___sitting ___bending ___working at a computer
• Please list any major illnesses, injuries, falls, auto accidents, or surgeries, including dates. Women provide information including child birth. _____
_____
• Have you been treated for any health condition by a physician within the last year? YES / NO
• Are you having any other problems you would like us to be aware of?_____
_____
• Please describe what expectations you have while under care at the Holistic Center for Vibrant Health.
_____
_____

Please circle areas of pain and injury:



Patient/Guardian Signature:_____ Date: _____

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