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

Name:____

Personal Medical History

Significant Illness

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

Please check if you experienced ANY of the following:

General

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

Skin and Hair

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

Head, Eyes, Ears, Nose and Throat

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

Name:____

Cardiovascular

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

Gastrointestinal

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

Genito-Urinary

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

Gynecology & Pregnancy

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

Neuro-Psychological

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

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.

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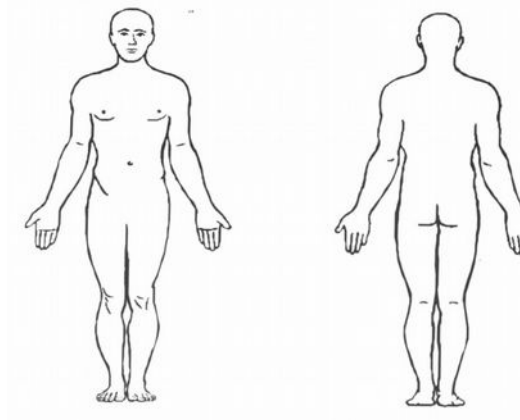
____

Please circle areas of pain and injury:



Patient/Guardian Signature:____ Date:
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