



General Intake Form

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General Information:

Name: Sex: M F Marital Status:
Address: Postal Code:
Phone: Home: Work: Birth Date:
Occupation: Email:
Next of Kin: Phone #:
Name/address of present physician(s):
How did you learn of this clinic?

Would you like to be added to our e-newsletter: yes no

Height: Current Weight: Lowest adult weight: Max weight: Height:

Please describe your major concerns and/or symptoms. Please be clear and concise to help us help you better. Include when the symptoms first began. What you can in the space provided. If you need more space, please attach the separate piece of paper provided.

If you have seen other physicians for these concerns, indicate the results of these evaluations:

Please bring medical records, if possible, especially lab tests or hospital discharge summaries.

What habits, activities or attitudes do you consider to have contributed to any of your concerns?

Are you currently receiving psychiatric care or undergoing psychological counseling? Y N

Health History: Please indicate if you have any of the following conditions (circle)

- Kidney disease Diabetes Migraines Headaches Hypoglycemia Breast feeding
Stroke Depression Asthma Gout Cancer Skin condition
Allergies Lung disease Anemia Arthritis Fainting Mental illness
Hemorrhoids Fibromyalgia Acne Anorexia Anxiety Bloating/gas
Indigestion Bronchitis Cold sores Constipation Dandruff Diarrhea
Weight gain Weight loss Emphysema Hair loss Heartburn
Herpes Hot flashes Insomnia HIV Kidney stones Cirrhosis
Liver disease Loose stool Poor memory Confusion Panic attacks Ulcer
Incontinence Hearing loss Respiratory problems Suicidal tendencies
Pneumonia Poor nail growth Gallbladder removed
Thyroid problems High cholesterol Addiction (drugs/alcohol)
Chronic Fatigue Intestinal problems Chronic cold or flu symptoms
Bladder infections Viral or bacterial disease High blood pressure
Ringing in the ears Neurological disease Irregular menstruation
Painful menstruation Loss of menstruation Painful intercourse
Menopause Endometriosis Infertility
Other

Please list any **previous** illnesses, accidents, and hospitalizations you have had including dates: _____

Please list medications, vitamins, minerals, and supplements you are presently taking: _____

Do you have allergies or sensitivities to any medications? Please name drugs and reactions). _____

Medical History: Please indicate which of the following conditions you or your family (parents, siblings, aunts, uncles, grandparents, etc) has. Beside each condition specify who including yourself experiences them.

Alcoholism: _____ High Cholesterol: _____

Allergies: _____ Frequent Infections: _____

Arthritis: _____ Urinary Tract Infections: _____

Anemia: _____ Polio: _____

Angina: _____ Lupus: _____

Asthma: _____ Mental Illness: _____

Bleeding/Bruising: _____ Migraines/Headaches: _____

Cancer: _____ Pneumonia: _____

Convulsions/Epilepsy: _____ Prostate Problems: _____

Crohn's Disease: _____ Sinus Problems: _____

Diabetes: _____ Strokes: _____

Digestive Disorders: _____ Heart Attacks: _____

Herpes/Shingles: _____ Thyroid Problems: _____

Hypoglycemia: _____ Tuberculosis: _____

Drug Problems: _____ Ulcers: _____

Eczema/Psoriasis: _____ Weight Problems: _____

Hepatitis: _____ Rheumatic Fever: _____

High Blood Pressure: _____ Venereal Disease: _____

Other: _____

Previous Medical Tests: If know, please specify date of test and results. If possible, please bring most recent results to the first appointment.

Last physical exam: _____ Stress test: _____

X-rays: _____ Angiogram: _____

GI series: _____ Ultrasound tests: _____

Kinney/bladder series: _____ Catheterization: _____

Gallbladder tests: _____ Blood tests: _____

EKG: _____ Allergy testing: _____

Other: _____

Previous Immunizations: Specify when if known:

Small Pox: _____ Tetanus: _____ Polio: _____

Flu: _____ Mumps: _____ Measles: _____

Rubella: _____ Pneumonia: _____ Diphtheria: _____

Pertussis: _____ Other: _____

Have you ever been on prolonged antibiotic therapy or have you used them frequently? (I.E. Erythromycin, Penicillin, Tetracycline, Sulfa Drugs, Flagyl, etc.)? _____

Lifestyle:

Do you smoke? **Y N** (if yes, when did you start and how often do you smoke? _____

Did you ever smoke? **Y N** When did you start? _____ When did you quit? _____

How long did you smoke? _____

Are you regularly exposed to second hand smoke? **Y N** Where? _____

Do you use recreational drugs? **Y N**

If yes, when did you start and how often do you use them? _____

What types of recreational drugs have you used? _____

What types of non-prescription medications do you use? (i.e. laxatives, antihistamines, decongestants, analgesics, stimulants, etc.) _____

Do you have any other allergies or sensitivities? (food, pollens, animals, chemicals, etc) _____

Are you regularly exposed to industrial or environmental chemicals, pollution, smog, or pesticides? **Y N** bAre you regularly exposed to industrial or environmental chemicals, pollution, smog, or pesticides? **Y N**

If you answered Y, which ones are you exposed to? _____

Do you currently have any pets? **Y N**

Describe the emotional climate of your home/work? _____

What do you do to relax? (i.e. hobbies) _____

Do you exercise regularly? **Y N**

How often do you exercise? _____ Length of session: _____

What type of exercise do you do? _____

Circle the following illnesses you had as a child:

Colic Eczema Asthma Polio Allergies Bronchitis Pneumonia Meningitis Rheumatic Fever Recurrent Colds

Ear Infections Thrush German Measles Bedwetting Tonsillectomy Persistent Diaper Rash

Learning Disability Hyperactivity Other: _____

Have you ever traveled out of the country? **Y N** Have you ever had "Traveler's Diarrhea?" **Y N**

Have you ever been treated for parasites? **Y N** Have you ever been tested for intestinal parasites? **Y N**

How much sleep do you get per night? _____

How often do you have a bowel movement? _____