CLINICAL INTAKE FORM / HEALTH HISTORY

Name: _____ Age: _____ Sex: M F

Date of Birth: _____

Present Physical Complaints: _____

_____

_____

Onset and Length of Symptoms: _____

_____

_____

At or around the time of onset were there other emotional stresses occurring? _____

_____

_____

List any medications you are presently taking:

List any supplements, herbs, homeopathic, over the counter medications you are presently taking:

Do you have any allergies? _____

To What?

Do you see any other practitioners? (Acupuncturist, chiropractor, massage therapist, etc.) For what health ailments?

Present weight: _____ One year ago: _____ 5 years ago: _____

PAST MEDICAL HISTORY

Please list year performed or diagnosed on #1 through #4.

1. Surgical History:

2. Hospitalizations:

3. Illnesses or Chronic Diseases:

4. Childhood accidents or physical traumas:

List any Medications you took as a child:

How long did you take them?

Do you have or have you had any of the following? ***Place a "P" for past and "C" for current.***

General: ___ fatigue ___ malaise ___ frequent cold or flu
___ Fever ___ cancer ___ weight gain
___ Hypoglycemia or low blood sugar ___ weight loss

HEENT: ___ vision change ___ double vision ___ spots before the eyes
___ use glasses ___ other vision problem
___ earache ___ ringing in ears ___ other ear problems
___ nasal problems ___ sinus problems ___ sore throat
___ mouth sores ___ dental problems ___ other throat/mouth problems
___ head or neck problems

Pulmonary: ___ wheezing ___ painful breathing ___ shortness of breath
___ spitting up blood ___ chronic cough ___ asthma
___ pneumonia ___ bronchitis ___ other lung problems

Cardiac: ___ chest pain ___ heart attack ___ palpitations
___ heart murmur ___ leg swelling/edema
___ arrhythmia ___ short of breath w/ exertion
___ congestive heart failure ___ coronary artery disease
___ congenital heart disease

Breast: ___ breast masses ___ fibrocystic breast disease
___ Breast pain ___ nipple discharge ___ breast cancer

Gastrointestinal:
___ Diarrhea ___ change in stools ___ bloody stools
___ Constipation ___ reflux/heartburn ___ ulcers
___ Hepatitis ___ other liver disease ___ gallbladder disease

Genitourinary: ___ painful urination ___ blood in urine ___ get up at night to urinate
___ urinate often ___ feel urgency to urinate often
___ incontinence ___ incomplete emptying of bladder
___ kidney stones ___ kidney disease ___ bladder disease

Musculoskeletal: ___ sprains ___ fractures
___ Arthritis ___ muscle pain ___ muscle weakness
___ Joint pain ___ other musculoskeletal disorders

Neurological: ___ headache ___ dizziness ___ fainting
___ Numbness ___ trouble walking ___ seizure
___ Brain or spinal tumor ___ other neurological disorders

Psychiatric: ___ depression ___ crying ___ anxiety
___ Eating disorder ___ other psychiatric disorder

Dermatology: ___ rash ___ fungal infections ___ acne
___ Skin ulcers ___ other skin problems

Endocrine: ___ dry skin ___ abnormal thirst ___ hot flashes
___ Thyroid problems ___ adrenal problems
___ Diabetes ___ pituitary problems

Hematologic: ___ anemia ___ bruise frequently ___ cuts do not stop bleeding
___ Enlarged lymph nodes ___ other hematological/lymphatic problem

FAMILY HISTORY (Referring to the list above, list any medical conditions, or problems in family members and the age of the diagnosis.)

Mother:

Father:

Siblings:

Mother's family (parents, siblings):

Father's family (parents, siblings):

Other:

LIFESTYLE:

Tobacco Use: Yes No How much and how often: _____

Alcohol Use: Yes No How much and how often: _____

Caffeine Use: Yes No How much and how often: _____

How frequently do you exercise? Daily _____ Weekly _____ Rarely _____

Type of exercise: _____

DIET:

Breakfast: _____

Lunch: _____

Dinner: _____

How many meals per week do you order or dine out? _____

Do you eat organic food? None / Some / Mostly / Exclusively

Home many times per week do you have?

Beef	_____	White rice	_____	Soda Pop	_____
Pork	_____	White bread	_____	Coffee	_____
Fish	_____	Crackers	_____	Black tea	_____
Chicken	____	Chips	_____	Milk	_____
Ice cream	____	Other dairy	_____	Canned Foods	_____

Desserts _____

How many glasses of water do you drink daily? _____

What would you say is the worst thing that you do on your diet? _____

_____

DIGESTION

Appetite: good fair poor Explanation: _____

Digestion: good fair poor Explanation: _____

Do you experience bloating or gas after meals? _____

Do you have sour burps? _____ Heartburn? _____

Do you fell sleepy or tired after meals? _____ How often? Daily / Weekly / Occasionally

Are you on a restricted diet? _____ Explain: _____

SLEEP

How many hours of sleep do you get on an average night? _____

Do you have any difficulties getting to sleep? _____

Do you usually wake up feeling tired? _____ If so, how often and why? _____

_____

Do you have difficulties falling back to sleep if you awaken? _____

STRESS LEVEL

What would you rate your level of stress (0=no stress, 10=maximum stress) _____

What are the major sources of stress in your life? _____

_____

Who provides you support in your life? _____

Nerves? Good _____ Fair _____ Poor _____

Anxiousness: Often _____ Sometimes _____ Seldom _____

Depression: Often _____ Sometimes _____ Seldom _____

EMOTIONAL AND SPIRITURAL

Marital status: single / married / widowed / divorced

If romantically involved, how is your relationship? _____

Were there any emotional traumas in your early or present life? Please explain briefly.
(ie. Rape, great loss, suicide or death of a loved one, etc.) _____

_____

_____

If possible, please explain what you feel to be your most experienced negative emotion:

_____

When do you most often feel this emotion? _____

Where are you, when you feel this negative emotion? _____

What is your opinion of yourself? _____

Have you ever been to counseling? _____ What was the outcome for you? _____

_____

Do you pray to a higher power? ____ How often? _____

Do you meditate? _____ If so, how often? _____

Rate Yourself:	None	Some	Lots
Faith	O	O	O
Hope	O	O	O
Charity	O	O	O
Generosity	O	O	O
Humor	O	O	O
Fun	O	O	O

Is there an unrealized longing in your life? _____ What is it? _____

_____

Briefly explain your relationship with each of your parents? _____

_____

WORK AND RECREATIONAL ACTIVITIES?

Occupation: _____

Do you enjoy your work? _____

Are you involved with activities outside of work? _____

If so, what type of activities? _____

FOR WOMEN ONLY

Date and results of last:

1. Gynecological exam: _____
2. Pap: _____
3. Mammogram: _____
4. Bone Density / DEXA scan: _____
5. Flexible sigmoidoscopy: _____

Or colonoscopy: _____

How many pregnancies? ____ Number of deliveries? _____ Vaginal _____ C-Section ___

Any complications? _____

Have you had any miscarriages? ___ If so, when? _____

Have you had any abortions? _____ If so, when? _____

Have you had any problems with infertility? _____

Method of contraception: _____

Do you have difficulty achieving orgasm? _____

Do you have any pain with intercourse? _____

Do you have any bleeding with intercourse? _____

Do you have a satisfying love life? _____

Are you currently sexually active? _____

Do you have any problems with incontinence (difficulty holding your urine)?_____

Any problems with:

_____ PMS symptoms	_____ vaginal infections	_____ pelvic infections (PID)
_____ Ovarian cysts	_____ vaginal candidiasis	_____ endometriosis
_____ Ovarian cancer	_____ abnormal paps	_____ STDs
_____ Cervical cancer	_____ cervical dysplasia	_____ Herpes
_____ Uterine cancer	_____ fibroids	_____ HPV

Date of last menstrual period? _____

MENSTRUAL PATTERN (check all that apply):

Symptom:	YES	NO	Explanation
Painful Menstruation	O	O	_____
Clots	O	O	_____
Irregular	O	O	_____

Dark Blood at Onset	O	O	_____
Dark Blood at conclusion	O	O	_____
Heaviness in lower pelvis	O	O	_____
Weak or numb legs	O	O	_____

Other: _____

MENOPAUSE:

Have you entered menopause yet? _____ If so, at what age? _____

Please check below if you have experienced any of the following:

O Hot flashes O Memory loss O Depression O Insomnia

O Mood swings O fatigue O Discharge O Heavy discharge

Color of discharge: _____

Do any of the women on your mother's side of the family suffer from any of the following?

O Infertility O Menstrual Problems O Difficult menopause

Are you now, or have you ever taken:

O birth control pills O Hormone replacement therapy?

If so, for how long? _____

FOR MEN ONLY

Any problems with:

_____ prostatitis

_____ Enlarged prostate (BPH)

_____ Prostate cancer

_____ Other disease of prostate

_____ Infections

_____ Impotence

_____ Problems with infertility

_____ Sexual dysfunction

Do you have difficulty achieving orgasm? _____

Do you have any pain with intercourse? _____

Do you have a satisfying love life? _____

Do you have any problems with incontinence (difficulty holding your urine)? _____

Date of last colonoscopy? _____