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INTAKE & HEALTH HISTORY

Name ______________________________ Today's Date ______________

Address ______________________________ City __________ State ______ Zip ______

Age ______ DOB ______________ Gender M F

Preferred Phone ______________________ Type (circle) Cell Home Work

Alternate Phone ______________________ Type (circle) Cell Home Work

Email ____

Emergency Contact ______________________ Relation ______________

Emergency Contact Phone ______________________________

What would you like support with at this time?

____

____

____

____

Please list your major health concerns/stressors. How long occurring?

1. ______________________________ ______________
2. ______________________________ ______________
3. ______________________________ ______________
4. ______________________________ ______________
5. ______________________________ ______________

Name of Physician ______________________ Last Visit (M/Y) ____________

Name of Gynecologist ______________________ Last Visit (M/Y) ____________

Other practitioners currently seeing (type and name):

____

____

Lifestyle

Marital Status ______________________________ # of times Married/Partnered __________

Currently sexually active? Yes No Number of current partners: ______

Birth Control Method (if applicable) ____

Current Occupation ______________________________ How long? ______ Hrs/Week? ______

Do you enjoy your work? ____

Passions/Interests? ____

Sleep/Energy Level

How many hours do you sleep? __________________ Do you sleep well? __________________

Trouble falling asleep? __________________ Wake during night? __________________

Do you wake rested? ______________________________ Use alarm to wake? ______________

How is your energy level during the day? ____

____

Activity Level

______ Sedentary (little exercise)

______ Light Activity (1-3 days per week)

______ Moderate Activity (3-5 days per week)

______ Very Active (6-7 days per week)

______ Extra Active (hard daily exercise)

Food/Other

Meals per day __________ Snacks per day __________

Typical Breakfast ____

Typical Lunch ____

Typical Dinner ____

Snacks ____

What kinds of foods do you crave? ____

Coffee (cups per day) __________ Tea (cups per day) ______ Type? __________________

Sodas (per week) __________ Diet or Regular? __________ Alcohol (drinks per week) __________

Cigarettes (per day) ______ Recreational Drugs ______________________________

____

Medical History (Hospitalized, Surgery, Major Illness)

Year	*Procedure/Illness*	*Treatments Received*

Medications/Herbs/Vitamins/Supplements (attach additional sheet if needed)

Type *Dosage* *For what condition?*

____

____

____

____

____

Are you allergic to aspirin? Yes No

Mark conditions/illnesses in yourself or blood relatives with an 'X.' Add additional information about your condition or identify relative (i.e. for yourself, when diagnosed; for relative, please identify mother, father, grandmother, grandfather, brother, sister, aunt, uncle, daughter, son).

Condition	**Self**	**Blood Relative**	**Details about Self or Identify Relative**
Addiction			
Allergies/Asthma			
Arthritis			
Cancer			
Depression			
Diabetes			
Digestive Issues			
Gynecological Issues			
Headaches/Migraines			
Heart Disease			
High Blood Pressure			
Kidney Disease			
Lyme Disease			
Mononucleosis			
Obesity			
Osteoporosis			
Respiratory Disease			
Stroke			
Thyroid Disease			

CURRENT AND PAST CONDITIONS / SYMPTOMS / TRAUMAS

If you are currently experiencing any of the following, please mark it with a “C”. If you have experienced any of the following in the past, please mark it with a “P”. If you have experienced the condition both in the past and currently, please mark it with a “P-C”.

General

________ Insomnia
________ Dreams / Nightmares
________ Fatigue
________ Poor Memory
________ Strongly like cold drinks
________ Strongly like hot drinks
________ Recent weight loss/gain
________ Cold hands & feet
________ Chills
________ Fever
________ Bad Breath
________ Other (describe)
____

Head & Neck

________ Headaches
________ Migraines
________ Stiff Neck
________ Dizziness
________ Fainting
________ Swollen Glands
________ Other (describe)
____

Ears

________ Ringing
________ Hearing Loss
________ Hearing Aids
________ Infections
________ Earache
________ Vertigo
________ Other (describe)
____

Eyes

________ Glasses / Contact Lenses
________ Blurred Vision
________ Poor Night Vision
________ Spots or Floaters
________ Eye Inflammation
________ Double Vision
________ Glaucoma
________ Cateracts
________ Other (describe)
____

________ How Often Checked?
____

Nose, Throat, & Mouth

________ Sinus Infection
________ Hay fever / Allergies
________ Frequent Sore Throat
________ Difficulty Swallowing
________ Mouth & Tongue Ulcers
________ Frequent Colds
________ Nosebleed
________ Dry Nose
________ Nasal Congestion
________ Loss of Voice
________ Thirst
________ Excessive Phlegm
________ TMJ
________ Facial Pain
________ Gum Problems
________ Dry Mouth
________ Other (describe)
____

________ Dental Problems? Last Visit
____

Skin

________ Hives
________ Rashes
________ Eczema / Psoriasis
________ Night Sweating
________ Excess Sweating
________ Dry Skin
________ Easily Bruised
________ Changes in Moles, Lumps
________ Itching
________ Other (describe)
____

Respiratory

________ Difficulty breathing
________ Difficulty breahting when reclining
________ Wheezing
________ Asthma
________ Chronic Cough
________ Wet Cough
________ Dry Cough
________ Coughing up Phlegm
________ Coughing up Blood
________ Shortness of breath
________ Tight Chest
________ Pneumonia
________ Other (describe)
____

Cardiovascular

________ High Blood Pressure
________ Low Blood Pressure
________ Chest Pain or Tightness
________ Palpitation
________ Rapid Heart Beat
________ Irregular Heart Beat
________ Poor Circulation
________ Swollen Ankles
________ Phlebitis
________ Anemia
________ History of Heart Disease
________ Heart Murmur
________ Night Sweats
________ Tendency to be Cold
________ Tendency to be Warm
________ Other (describe)
____

Gastrointestinal

________ Nausea
________ Indigestion
________ Stomach Pain
________ Diarrhea
________ Constipation
________ Poor Appetite
________ Excessive Hunger
________ Vomiting
________ Gas
________ Hiccups
________ Acid Regurgitation
________ Bloating
________ Laxative Use
________ Bloody Stool
________ Other (describe)
____

Musculoskeletal

________ Joint Pain / Swelling
________ Sore Muscles
________ Weak Muscles
________ Difficulty Walking
________ Limited Range of Motion
________ Pain (describe)
____
____
____

________ Other (describe)
____

Neurological

________ Seizures
________ Tremors
________ Numbness or Tingling
________ Paralysis
________ Poor Coordination
________ Pain (describe)
____

________ Other (describe)
____

Mental / Emotional

________ Depression
________ Mood Swings
________ Irritability
________ Difficulty Relaxing
________ Loneliness
________ Sensitive
________ Shyness
________ Frequent Crying
________ Worry Frequently
________ Compulsive Behaviors
________ Difficulty Focusing
________ Hopeless Outlook
________ Suicidal Thoughts
________ Lose Temper
________ Frustration

________ Other (describe)
____

Urinary

________ Pain on Urination
________ Frequent Urination
________ Urgent Urination
________ Blood in Urine
________ Incontinence
________ Incomplete Urination
________ Bedwetting
________ Wake to Urinate
________ History of UTI
________ Kidney (specify)
____
____

________ Other (describe)

Male Genital

________ Impotence
________ Premature Ejaculation
________ Nocturnal Emission
________ Pain / Itching of Genitals
________ Lumps in Testicles
________ Increased Libido
________ Decreased Libido
________ Breast Checked

________ Other (describe)
____

Gynecology (Women Only)

________ Currently Pregnant
________ # of Pregnancies
________ # of Live Births
________ # of Miscarriages
________ # of Abortions
________ Menopause
________ Irregular Periods
________ Menstrual Cramps
________ Excessive Blood Flow
________ Menstrual Blood Clots
________ Breast Tenderness
________ Abnormal Pap Smear
________ Vaginal Infections
________ Vaginal Pain / Itching
________ Uterine Fibroids
________ Endometriosis
________ Breast Lumps, Cysts
________ Increased Libido
________ Decreased Libido
________ Other (describe)
____

Infection Screening (circle self and/or partner)

________ HIV Risks: Self / Partner
________ TB: Self / Partner
________ Hepatitis Risk: Self / Partner
________ History of Sexually Transmitted Disease: Self / Partner (specify)
____
____

________ Other (describe)
____

Trauma (List)

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Other Information

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