New Patient Intake Form

Name_____ Age_____ DOB_____

Address: _____ City _____ Zip _____

Phone : cell _____ home _____

Email _____

Who may we thank for referring you? _____

Sex: M F Marital Status: married single divorced separated

widow(er) other_____

Children_____ Names and ages_____

_____

Other significant relationships_____

Current living situation_____

Do you have pets? _____

Daily schedule/activities (include work) _____

_____

_____

_____

Daily physical exercise_____

_____

_____

Personal health/medical history (diagnosis, surgeries, illnesses, etc)

_____

_____

_____

_____

Current medications, supplements, vitamins, herbs, homeopathics, etc.

_____

_____

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_____

_____

Dental issues (fillings, root canals, bridges) _____

_____

_____

Family health/medical history: parents, siblings, children (diagnosis, surgeries, illnesses, dental issues, etc) _____

_____

_____

_____

_____

Social/emotional history _____

_____

_____

_____

Family and personal relationship history _____

_____

_____

_____

Where did you grow up? _____

_____

Weight: _____ lbs. Weight 1 year ago: _____ lbs.

Maximum weight: _____ lbs. When: _____

Height: _____ ft _____ in.

Diet _____

_____

_____

_____

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How much water do you drink per day? _____

Is it tap water? Source? Well? Bottle? _____

What else do you drink? _____

Are you constipated? Yes _____ No _____

How many BM per day? _____

How would you describe your digestion?_____

_____

_____

_____

Do you average 6-8 hours sleep? _____Yes _____ No

If no, how many? _____

Do you sleep well? _____Yes _____ No

If no, what is the problem? _____

_____

Do you awaken rested? _____Yes _____ No

If no, what is the problem? _____

_____

When is your energy the best during the day?

_____

Worst? _____

Do you enjoy your work? _____Yes _____ No

If no, why not? _____

_____

If yes, please list the reasons you do enjoy it. _____

_____

Do you spend time outside? _____Yes _____ No

If yes, how much and what do you do? _____

_____

Do you watch television? _____Yes _____ No

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If yes, what and how much? _____

_____

Do you read? _____Yes _____ No

If yes, what and how much? _____

_____

Do you take vacations? _____Yes _____ No

If yes, how long and what kind? _____

_____

Do you meditate?___Yes ____No If yes, for how many years/months?____Y ____M

For women :

Are you on birth control pills? ___ Yes ___ No If yes, for how long and what kind?

_____

_____

If applicable, do you experience hot flashes or other menopausal issues? Please describe.

_____

_____

_____

_____

If you have children, please elaborate. # of children, vaginal or cesarean births, any complications?

_____

_____

Did you breast-feed or bottle- feed?

For men: Have you been diagnosed with low testosterone? ____Yes _____ No

Do you have any diagnosed prostate issue? ____ Yes ____ No If yes, please elaborate.

_____

_____

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For both : If applicable, are you happy with your sex life? Any libido issues?

As far as you know, were you born by cesarean section or were you a vaginal birth?

What are your top 2 short term goals and your top 2 long term goals in life?

Short term 1:

Short term 2:

Long term 1:

Long term 2:

What have you tried so far that did not deliver the results you were expecting?

What have you tried that has been somewhat helpful?

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_____

What do you feel needs to happen for you to get better? _____

_____

_____

_____

_____ _____

What do you enjoy most in life? _____

_____

_____

_____

How much change are you willing to make at this time to improve your health?

_____

_____

_____

Is there anything else I need to know? _____

_____

_____

_____

_____

Thank you!

Intake information is private and confidential. HIPAA privacy rules apply, your information is secure in our office and will not be shared.