PATIENT INTAKE FORM

Thank you for taking the time to fill out this form and provide us with details of your health, goals and medical history. Feel free to save this form to your computer and type in your answers at your convenience. The boxes where you type your responses will expand to accommodate your text, so you will have as much space as you need.

Patient Information

Name _____

Address _____

City _____

State _____ Zip Code _____

Phone (day) _____

Phone (cell) _____

Phone (night) _____

Email _____

Referred by _____

Statistics

Age _____

Birth Date _____

Gender _____

Height _____

Blood Type _____

Current Weight _____

Ideal Weight _____

Weight One Year Ago _____

Birth Weight (if known) _____

Birth Order (please list ages of biological siblings): _____

Family/Living Situation: _____

_____

Children: _____

_____

Occupation: _____

_____

Exercise/Recreation: _____

_____

History

1. Have you lived or traveled outside of the United States? If so, when and where?:

2. Have you or your family recently experienced any major life changes? If so, please comment:

3. Have you experienced any major losses in life? If so, please comment:

4. How much time have you had to take off from work or school in the last year?

   - ☐ 0 to 2 days
   - ☐ 3 to 14 days
   - ☐ more than 15 days

Health Concerns

5. What are your main health concerns? (Describe in detail, including the severity of the symptoms):

6. When did you first experience these concerns?

7. How have you dealt with these concerns in the past?

   - ☐ doctors
   - ☐ self-care

8. Have you experienced any success with these approach es?

9. What other health practitioners are you currently seeing? List nam e, specialty and phone # below.

10. Please list the date and description of any surgical procedures yo u have had (including breast reduction or augmentation).

11. How often did you take antibiotics in infancy/childhood?

12. How often have you taken antibiotics as a teen?

13. How often have you taken antibiotics as an adult?

14. List any medicine you are currently taking:

15. List all vitamins, minerals, herbs and nutritional supplements you are now takin g:

16. Have any other family members had similar problems (describe)?

Nutritional Status

17. Are there any foods that you avoid because of the way they make you feel?
    If yes, please name the food and the symptom:

18. Do you have symptoms immediately after eating like bloating, ga s, sneezing or hives?
    If so, please explain:

19. Are you aware of any delayed symptoms after eating certain foods s uch as fatigue, muscle aches, sinus congestion, etc? If so, please explain:

20. Are there foods that you crave? If so, please explain:

21. Describe your diet at the onset of your health concerns:

22. Do you have any known food allergies or sensitivities?

23. Which of the following foods do you consume regularly?

- ☐ soda
- ☐ diet soda
- ☐ refined sugar
- ☐ alcohol
- ☐ fast food
- ☐ gluten (wheat, rye, barley)
- ☐ dairy (milk, cheese, yogurt)
- ☐ coffee

24. Are you currently on a special diet?

- ☐ autoimmune paleo (AIP)
- ☐ SCD/GAPS
- ☐ dairy restricted or dairy-free
- ☐ vegetarian
- ☐ vegan
- ☐ Other (please describe)
- ☐ paleo
- ☐ blood type
- ☐ raw
- ☐ refined sugar-free
- ☐ gluten-free

25. What percentage of your meals are home-cooked?

☐ 10	☐ 30	☐ 50	☐ 70	☐ 90
☐ 20	☐ 40	☐ 60	☐ 80	☐ 100

26. Is there anything else we should know about your c urrent diet, history or relationship to food?

Intestinal Status

27. Bowel Movement Frequency

- ☐ 1–3 times per day
- ☐ more than 3 times per day
- ☐ not regularly every day

28. Bowel Movement Consistency

- □ soft & well formed
- □ often float
- □ difficult to pass
- □ diarrhea
- □ thin, long or narrow
- □ small and hard
- □ loose but not watery
- □ alternating between hard and loose

29. Bowel Movement Color

- □ medium brown
- □ very dark or black
- □ greenish
- □ blood is visible
- □ variable
- □ yellow, light brown
- □ chalky colored
- □ greasy, shiny

30. Do you experience intestinal gas? If so, please explain if it is e xcessive, occasional, odorous, etc:

31. Have you ever had food poisoning? If yes, please descri be in detail, including 1) Where were you 2) What did you treat it with and 3) If you feel like you fully recovered from it:

Medical Status

32. Please identify any current or past conditions and add a date for when the condition appeared. In the space below each list, please briefly describe yo ur symptoms, chosen treatment(s), and dates.

Gastrointestinal

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	☐_____	Irritable Bowel Syndrome	☐	☐	☐_____	Gut infections
☐	☐	☐_____	Crohn's	☐	☐	☐_____	Dysbiosis
☐	☐	☐_____	Ulcertative Colitis	☐	☐	☐_____	Leaky gut
☐	☐	☐_____	Gastritis or Peptic Ulcer Disease	☐	☐	☐_____	Food allergies, intolerances or reactions
☐	☐	☐_____	GERD (reflux or heartburn)	☐	☐	☐_____	Gallstones
☐	☐	☐_____	Celiac Disease	☐	☐	☐_____	Known absorption or assimilation issues
☐	☐	☐_____	SIBO	☐	☐	☐_____	Other

Please briefly describe your symptoms, chosen treatm ent(s) and dates:

Cardiovascular

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	☐_____	Heart attack	☐	☐	☐_____	Hypertension (high blood pressure)
☐	☐	☐_____	Heart Disease	☐	☐	☐_____	Rheumatic Fever
☐	☐	☐_____	Stroke	☐	☐	☐_____	Mitral Valve Prolapse
☐	☐	☐_____	Elevated cholesterol	☐	☐	☐_____	Other
☐	☐	☐_____	Arrhythmia (irregular heartbeat)				

Please briefly describe your symptoms, chosen treatm ent(s) and dates:

Hormones/Metabolic

PAST	NOW	DATE	
☐	☐	☐_____	Type 1 Diabetes
☐	☐	☐_____	Type 2 Diabetes
☐	☐	☐_____	Hypoglycemia
☐	☐	☐_____	Metabolic Syndrome
☐	☐	☐_____	Insulin Resistance or Pre-Diabetes
☐	☐	☐_____	Hypothyroidism (low thyroid)
☐	☐	☐_____	Hyperthyroidism (overactive thyroid)
☐	☐	☐_____	Hashimoto's (autoimmune hypothyroid)
☐	☐	☐_____	Grave's Disease (autoimmune hyperthyroid)

PAST	NOW	DATE	
☐	☐	☐_____	Endocrine problems
☐	☐	☐_____	Polycystic Ovarian Syndrome (PCOS)
☐	☐	☐_____	Infertility
☐	☐	☐_____	Weight gain
☐	☐	☐_____	Weight loss
☐	☐	☐_____	Frequent weight fluctuations
☐	☐	☐_____	Eating disorder
☐	☐	☐_____	Menopause difficulties
☐	☐	☐_____	Hair loss
☐	☐	☐_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Cancer

PAST	NOW	DATE	
☐	☐	☐_____	Lung Cancer
☐	☐	☐_____	Breast Cancer
☐	☐	☐_____	Colon Cancer
☐	☐	☐_____	Ovarian Cancer

PAST	NOW	DATE	
☐	☐	☐_____	Prostate Cancer
☐	☐	☐_____	Skin Cancer (Melanoma)
☐	☐	☐_____	Skin Cancer (Squamous, Basal)
☐	☐	☐_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Genital & Urinary Systems

PAST	NOW	DATE	
☐	☐	☐_____	Kidney Stones
☐	☐	☐_____	Gout

PAST	NOW	DATE	
☐	☐	☐_____	Interstitial Cystitis
☐	☐	☐_____	Frequent urinary tract infections

☐ ☐ ☐_____ Erectile Dysfunction or Sexual Dysfunction

☐ ☐ ☐_____ Frequent Yeast Infections

☐ ☐ ☐_____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Musculoskeletal/Pain

PAST NOW DATE

☐ ☐ ☐_____ Osteoarthritis

☐ ☐ ☐_____ Fibromyalgia

☐ ☐ ☐_____ Chronic Pain

PAST NOW DATE

☐ ☐ ☐_____ Sore muscles or joints, undiagnosed

☐ ☐ ☐_____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Immune/Inflammatory

PAST NOW DATE

☐ ☐ ☐_____ Chronic Fatigue Syndrome

☐ ☐ ☐_____ Rheumatoid Arthritis

☐ ☐ ☐_____ Lupus SLE

☐ ☐ ☐_____ Raynaud's

☐ ☐ ☐_____ Psoriasis

☐ ☐ ☐_____ Mixed Connetive Tissue Disease (MCTD)

☐ ☐ ☐_____ Poor immune function (frequent infections)

☐ ☐ ☐_____ Food allergies

PAST NOW DATE

☐ ☐ ☐_____ Environmental allergies

☐ ☐ ☐_____ Multiple chemical sensitivities

☐ ☐ ☐_____ Latex allergy

☐ ☐ ☐_____ Hepatitis

☐ ☐ ☐_____ Lyme (and co-infections)

☐ ☐ ☐_____ Chronic Infections (Epstein-Barr, Cytomegalo - virus, Herpes, etc.)

☐ ☐ ☐_____ Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Respiratory Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	☐_____	Asthma	☐	☐	☐_____	Pneumonia
☐	☐	☐_____	Chronic Sinusitis	☐	☐	☐_____	Sleep Apnea
☐	☐	☐_____	Bronchitis	☐	☐	☐_____	Frequent or recurrent Colds/Flus
☐	☐	☐_____	Emphysema	☐	☐	☐_____	Other

Please briefly describe your symptoms, chosen treatm ent(s) and dates:

Skin Conditions

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	☐_____	Eczema	☐	☐	☐_____	Acne
☐	☐	☐_____	Psoriasis	☐	☐	☐_____	Skin Cancer (Melanoma)
☐	☐	☐_____	Dermatitis	☐	☐	☐_____	Skin Cancer (Squamous, Basal)
☐	☐	☐_____	Hives	☐	☐	☐_____	Other
☐	☐	☐_____	Rash, undiagnosed				

Please briefly describe your symptoms, chosen treatm ent(s) and dates:

Neurologic/Mood

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	☐_____	Depression	☐	☐	☐_____	Mild Cognitive Impairment
☐	☐	☐_____	Anxiety	☐	☐	☐_____	Memory problems
☐	☐	☐_____	Bipolar Disorder	☐	☐	☐_____	Parkinson's Disease
☐	☐	☐_____	Schizophrenia	☐	☐	☐_____	Multiple Sclerosis
☐	☐	☐_____	Headaches	☐	☐	☐_____	ALS
☐	☐	☐_____	Migraines	☐	☐	☐_____	Seizures
☐	☐	☐_____	ADD/ADHD	☐	☐	☐_____	Alzheimer's
☐	☐	☐_____	Autism	☐	☐	☐_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

Miscellaneous

PAST	NOW	DATE		PAST	NOW	DATE	
☐	☐	_____	Anemia	☐	☐	_____	Sleep Apnea
☐	☐	_____	Chicken Pox	☐	☐	_____	Whooping Cough
☐	☐	_____	German Measles	☐	☐	_____	Tuberculosis
☐	☐	_____	Measles	☐	☐	_____	Known genetic variants (SNPs, polymorphisms, etc)
☐	☐	_____	Mononucleosis	☐	☐	_____	
☐	☐	_____	Mumps	☐	☐	_____	Other

Please briefly describe your symptoms, chosen treatment(s) and dates:

33. Please check frequency of the following:

Short term memory impairment	☐ yes	☐ no	☐ sometimes
Shortened focus of attention and ability to c oncentrate	☐ yes	☐ no	☐ sometimes
Coordination and balanc e problems	☐ yes	☐ no	☐ sometimes
Problems with lack of inhibition	☐ yes	☐ no	☐ sometimes
Poor organization abilities	☐ yes	☐ no	☐ sometimes
Problems with time management (l ate or forget appts)	☐ yes	☐ no	☐ sometimes
Mood instability	☐ yes	☐ no	☐ sometimes
Difficulty understanding speech and word finding	☐ yes	☐ no	☐ sometimes
Brain fog, brain fatigue	☐ yes	☐ no	☐ sometimes
Lower effectiveness at work, home or school	☐ yes	☐ no	☐ sometimes
Judgment problems like leaving th e stove on, etc	☐ yes	☐ no	☐ sometimes

Health Hazards

34. Have you been exposed to any chemicals or toxic metals (lead, mercury, arsenic, aluminum)?

35. Do odors affect you?

36. Are you or have you been exposed to second-hand smoke?

Oral Health History

37. How long since you last visited the dentist? What was the reason for that visit?

38. In the past 12 months has a dentist or hygienist talked to you about yo ur oral health, blood sugar or other health concerns? (Explain.)

39. What is your current oral and dental regimen? (Please note wheth er this regimen is once or twice daily or occasionally and what kind of toothpaste you use.)

40. Do you have any mercury amalgams? (If no, were they removed? If so, how?)

41. Do you have any concerns about your oral or dental hea lth?

42. Is there anything else about your current oral or dental hea lth or health history that you'd like us to know?

Lifestyle History

43. Have you had periods of eating junk food, binge eating or dieting? List any known diet that you have been on for a significant amount of time.

44. Have you used or abused alcohol, drugs, meds, tobacc o or caffeine? Do you still?

45. How do you handle stress?

Sleep History

46. Are you satisfied with your sleep?

47. Do you stay awake all day without dozing?

48. Are you asleep (or trying to sleep) between 2:00 a.m. and 4:00 a.m.?

49. Do you fall asleep in less than 30 minutes?

50. Do you sleep between 6 and 8 hours per night?

For Women Only

51. How old were you when you first got your period?

52. How are/were your menses? Do/did you have PMS? Painful periods? If so, explain.

53. In the second half of your cycle do you experience any symptom s of breast tenderness, water retention or irritability?

54. Have you experienced any yeast infections or urinary tract infections ? Are they regular?

55. Have you/do you still take birth control pills: If so, please li st length of time and type.

56. Have you had any problems with conception or pregnancy?

57. Are you taking any hormone replacement therapy or horm onal supportive herbs? If so, please list again here.

Sexual History

58. Do you have any concerns or issues with your sexual functioning that you'd like to share with us (pain with intercourse, dryness, libido issues, erectile dysfunction)?

59. In the past year, have your sexual partners been men, wom en, or both? And how many partners have you had in the past year?

Mental Health Status

60. How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

61. On a scale of 1-10, one being the worst and 10 being the best, describe your usual level of energy.

62. At what point in your life did you feel best? Why?

Other

63. Do you think family and friends will be supportive of you making health and lifestyle changes to improve your quality of life? Explain, if no.

64. Who in you family or on your health care team will be most supportive of you m aking dietary change?

65. Please describe any other information you think would be useful in helping to a ddress your health concern(s):

66. What are your health goals and aspirations?

67. Though it may seem odd, please consider why you might want to achieve th at for yourself: