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CONFIDENTIAL INTAKE FORM

Date _____

Name: _____ Age: _____ Gender: _____

Date of Birth: _____ Occupation: _____

Home Address: _____

Home Phone: _____ Work Phone: _____

Cell: _____ Email: _____

What is your reason for Today's visit? _____

1. Briefly explain the history of your condition, i.e. how long have you had this condition; was the onset SUDDEN or GRADUAL; was there a significant event that lead to this?

2. Have you seen a physician (or other primary care provider) for this condition? If yes, when and what diagnosis did you receive?

3. What other therapies are you doing/ have you done to manage your condition, e.g. physical therapy, medication, chiropractic, etc.? Did these/ are these other therapies helping?

MEDICATIONS, SUPPLEMENTS AND HERBS

Please list all medications, (prescriptions and over-the-counter drugs) supplements and/or herbs you are **CURRENTLY** taking:

Medications, supplements, or herbs:	*Indication/For treatment of:*
1. _____	1. _____
2. _____	2. _____
3. _____	3. _____
4. _____	4. _____
5. _____	5. _____

LIST ANY ALLERGIES (to medications, supplements, herbs, foods or environmental factors):

_____

_____

PERSONAL MEDICAL HISTORY

ILLNESSES: List any surgeries, accidents & /or major illnesses? Please list in chronological order and indicate duration of illnesses.

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

AGE: _____ _____

FAMILY MEDICAL HISTORY

Please note all major illnesses in your close family, e.g. diabetes, heart disease, hypertension, neurological disorders, psychological disorders, blood disorders, cancer, high cholesterol, etc.

_____

_____

_____

_____

SYMPTOM OVERVIEW BY SYSTEM

Please circle all symptoms that you are CURRENTLY experiencing.

Cardiovascular:

Chest pain	Irregular heart beat	Swelling of the ankles or legs	Fatigue
Palpitations	Poor circulation	Cold hands and feet	Other (please list)

Muscles, Joints and Bones:

Are you experiencing any pain? Where? _____

The pain is (circle all that apply):

Sharp	Burning	Worse with application of heat	Worse in a.m.
Aching	Dull	Better with application of heat	Worse in p.m.
Numb	Superficial	Worse with application of cold	Better with movement
Deep	Tingling	Better with application of cold	Better with rest

I have (circle all that apply):

Limited range of motion	Muscle weakness	Repetitive strain	Arthritis/joint pain
Muscle Stiffness	Tendonitis	Bone pain	Muscle pain
Swollen joints	Muscle cramping	Other (please list)	

Respiratory: (Please circle all that apply):

Do you smoke? Yes No Amount per day: _____ For how long? _____

Do you cough up mucous? If so how much? _____ Color of phlegm? _____

Frequent colds	Shortness of breath	Wheezing	Difficulty inhaling
Cough	Asthma	Chest pain &/or tightness	Coughing blood

Other (please list):

Eyes, Ears, Nose Throat and Head: (Please circle all that apply):

Poor vision	See spots	Dizziness	Ringing in ears (high or low pitch)
Eye pain	Ear pain	Clogged/popping ears	Loss of hearing
Dry eyes	Vertigo	Nose bleeds	Sinus problems
Eye redness	Runny nose	Sore throat	Cold sores
Bleeding gums	Dry mouth	Frequent headaches	Migraines

Other (please list):

Skin and Hair: (Please circle all that apply):

Wounds that will not heal	Rashes	Dry skin	Psoriasis
Itching	Unusual sweating	Acne	Eczema
Hives	Changes in hair	Hair loss	Premature graying

Other (please list):

Urinary: (Please circle all that apply):

Frequent urination	Incontinence	Pain	Burning
Blood in the urine	Urinary tract infections	Difficulty with urine flow	Kidney stones

Other (please list):

Gastrointestinal: (Please circle all that apply):

Belching	Nausea	Vomiting	Vomiting blood
Indigestion	Heartburn	Acid regurgitation	Abdominal bloating/distension
Abdominal pain	Ulcers	Gas	Hemorrhoids
Painful bowel movements	Diarrhea	Constipation	Alternating constipation/diarrhea
Burning	Loose stool	Hard stool	Undigested food in stool
Blood in stool	Rectal Itchiness	Other: (Please list):	

Neurological: (Please circle all that apply):

Changes in consciousness	Confusion	Difficulty concentrating	Dizziness
Dysphasia (impaired ability to speak)	Gait disturbance	Headache	Numbness &/or tingling
Loss of consciousness	Paralysis	Severe forgetfulness	Tremor
Visual disturbance	Problems coordinating movements		Other: (please list):

Psychological: (Please circle all that apply):

Difficulty managing anger	Bad Temper	Panic attacks	Depression
Anxiety	Nervous	Fearful	Sadness
Grief	Overwhelmed	Manic	Worried or overly pensive
Mood swings	Lack of emotion	Poor memory	Other: (please list):

How do you feel about your personal relationships? _____

How do you feel about your work? _____

How do you relax? _____

Sleep: (Please circle all that apply):

Difficulty falling asleep Difficulty staying asleep Dream disturbed sleep

How many hours do you sleep per night? _____ Do you feel rested when you awake? _____

Do you tend to wake up at a certain time and have trouble falling asleep again? _____ What time? _____ am/pm

For Women Only: (Please circle all that apply):

Irregular menstruation	Heavy flow	Light flow	No flow
Pain before period	Pain during period	Clots	Spotting between periods
Vaginal itching/burning	Menopausal symptoms	Fertility concerns	Reduced sexual energy
Pain during sexual relations	Lumps in the breast	Breast tenderness	Other: (please list):

Unusual vaginal discharge? Yes No Amount _____ Color_____ Frequency_____

Blood or mucous discharge from breasts? Yes No Amount _____ Frequency_____

PMS symptoms: _____

Does anything relieve these symptoms? _____

What kind of birth control do you use? _____

Are you presently trying to get pregnant? Yes No Are you currently pregnant? Yes No

Number of pregnancies _____ Number of births_____ Number of miscarriages _____ Number of abortions _____

Pregnancy complications? Please describe: _____

Men Only: (Please circle all that apply):

Prostate problems	Fertility concerns	Unusual discharge	Impotence
Premature ejaculation	Reduced sexual energies	Seminal emission	Genital pain
Inguinal hernia	Other: **(**Please list):		

MEDICAL DISEASES/CONDITIONS. Please check all that apply, past and present:

- ☐ AIDS/HIV
- ☐ Hypertension
- ☐ Alcoholism &/or substance addiction
- ☐ Irritable Bowel Syndrome (IBS)
- ☐ Allergies
- ☐ Joint Replacement
- ☐ Anemia
- ☐ Lymph node removal
- ☐ Asthma
- ☐ Multiple Sclerosis
- ☐ Blood clotting disorder
- ☐ Osteoarthritis
- ☐ Cancer
- ☐ Osteoporosis
- ☐ Chron's Disease &/or colitis
- ☐ Pacemaker (heart or stomach)
- ☐ Chronic Fatigue Syndrome (CFIDS)
- ☐ Parkinson's Disease
- ☐ Depression (Major)
- ☐ Reflex esophagistis (GERD)
- ☐ Diabetes
- ☐ Rheumatoid arthritis
- ☐ Infertility
- ☐ Seizures and /or epilepsy
- ☐ Lung disease
- ☐ Stroke
- ☐ Fibromyalgia
- ☐ Thyroid disease
- ☐ Heart disease
- ☐ Tuberculosis
- ☐ Hepatitis A / B / C
- ☐ Lupus
- ☐ Hernia
- ☐ Kidney Stones and/or disease
- ☐ Herpes
- ☐ Lyme's Disease

Diet, food, energy and exercise:

How is your appetite? Good Poor No appetite Hungry all the time

Food cravings _____

Dietary restrictions _____

Rate your taste preferences 1 to 5 (1 being your least favorite and 5 being your most favorite)

Salty _____ Sour _____ Bitter _____ Sweet _____ Spicy _____

Are you always thirsty? Yes No How do you prefer your drinks? Hot Cold

How many glasses/cups do you have daily: Water_____ Soda_____ Coffee/Tea _____

Alcohol (drinks per day) _____ OR (drinks per week) _____

How is your energy? _____ Do you fatigue easily? _____

What time of day is your energy: Highest? _____ Lowest? _____

Do you exercise? _____ How often? _____

Does movement make you feel: Less tired or More tired