

CONFIDENTIAL PATIENT INTAKE INFORMATION

Patient Name: _____
First Middle Last

Name patient prefers to go by: _____

Birth Date: _____ Gender: Male Female

SSN: _____

Street: _____

City: _____ State: _____ Zip: _____

Contact Information

Home: _____

Work: _____

Cell: _____

Email Address: _____

For Pediatric Patients:

Father's Name _____

Mother's Name _____

We will **NOT** confirm your existence as a patient in this clinic or correspond with any family member or other person you have not specifically authorized. If you have another family member or caregiver with whom you wish for us to correspond, you will need to list them below.

Name _____

Relationship _____

HEALTH HISTORY

Please circle all conditions that you have or have had in the past.

- | | | |
|------------------------|------------------------------|----------------------|
| Cancer | Esophagitis | Hypothyroidism |
| Eczema | Peptic Ulcer | Hyperthyroidism |
| Psoriasis | Gastro Esophageal Reflux | Skin Conditions |
| Allergic Rhinitis | Colitis | Alzheimer's |
| Arthritis | Irritable Bowel | Parkinson's |
| Chronic Sinusitis | Pancreatitis | Asthma |
| Dementia | Gall Bladder Dysfunction | Seizure Disorder |
| Chronic Fatigue | Hepatitis | Liver Disease |
| Multiple Sclerosis | Fibrocystic Breast Cancer | Endometriosis |
| Vascular Disease | Kidney Problems | Fibroid Tumors |
| Fibromyalgia | Urinary Tract Infections | Ovarian Disease |
| Chemical Sensitivities | Benign Prostatic Hypertrophy | PMS |
| Heart Disease | Thrush | Menopause |
| Postpartum Depression | Stroke | Athletes Foot |
| Hypertension | Nail Fungus | Glaucoma |
| High Cholesterol | Ring Worm | Night Blindness |
| Diabetes | Yeast Infections | Herpes or Cold Sores |
| Restless Legs | Burning Mouth | Shingles |
| Autism | Asperger's | ADD/ADHD |
| Anxiety | Depression | Obsessive Compulsive |

Other _____

Past Surgeries: _____

Past Hospitalizations: _____

Other Treatments or Pertinent Tests: _____

Is there any special need or concern you have or would like me to be aware of?

PLEASE LIST ALL MEDICATIONS AND SUPPLEMENTS YOU ARE TAKING

Med/Supplement Dosage Purpose

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

If you have a primary provider or pediatrician please list below.

Name _____ Office Phone _____
Street _____
City _____ State _____ Zip _____

PRELIMINARY FUNCTIONAL ASSESSMENT QUESTIONNAIRE

Acid foods upset	rare	occasional	often
Nervous stomach	rare	occasional	often
Reduced Appetite	rare	occasional	often
Frequent Sour Stomach	rare	occasional	often
Reduced Urine output	rare	occasional	often
Stomach Butterflies	rare	occasional	often
Indigestion following meals	rare	occasional	often
Always feel hungry	rare	occasional	often
Frequent Vomiting	rare	occasional	often
Constipation	rare	occasional	often
Diarrhea	rare	occasional	often
Weight Gain	rare	occasional	often
Weight Loss without trying	rare	occasional	often
Decreased sugar tolerance	rare	occasional	often
Abnormal Thirst	rare	occasional	often
Abdominal Bloating	rare	occasional	often
Weight gain around hips	rare	occasional	often
Excessive Appetite	rare	occasional	often
Irritable before meals	rare	occasional	often
Shaky when hungry	rare	occasional	often
Eating relieves tiredness	rare	occasional	often
Light headed if meals missed	rare	occasional	often
Sweets upset stomach	rare	occasional	often
Meats upset stomach	rare	occasional	often
Metallic Taste in mouth	rare	occasional	often
Coated Tongue	rare	occasional	often
Frequent Foul Smelling Gas	rare	occasional	often

Eyes Sensitive to Light	rare	occasional	often
Unable to Relax	rare	occasional	often
Nerve-like pain	rare	occasional	often
Eyes blink often	rare	occasional	often
Difficulty Swallowing	rare	occasional	often
Eyelids or Face twitch	rare	occasional	often
Difficulty holding a gaze	rare	occasional	often
Restless	rare	occasional	often
Can't work under pressure	rare	occasional	often
Headaches upon rising	rare	occasional	often
Impaired hearing	rare	occasional	often
Failing memory	rare	occasional	often
Splitting Headaches	rare	occasional	often
Afternoon Headaches	rare	occasional	often
Ringing in Ear or Ears	rare	occasional	often
Dizziness	rare	occasional	often
Blurred Vision	rare	occasional	often

Cold Extremities	rare	occasional	often
Easily Chilled	rare	occasional	often
Pulse speeds after meals	rare	occasional	often
Racing Pulse at Rest	rare	occasional	often
Slow Pulse (Below 65)	rare	occasional	often
Increased Blood Pressure	rare	occasional	often
Decreased Blood Pressure	rare	occasional	often
Weakness	rare	occasional	often
Poor Circulation	rare	occasional	often
Respiratory Difficulty (Asthma)	rare	occasional	often
Heart Palpitates if missed meal	rare	occasional	often
Numbness of Hands or Feet	rare	occasional	often
Swollen Ankles	rare	occasional	often
Shortness of Breath on Exertion	rare	occasional	often
Shortness of Breath at Rest	rare	occasional	often
History of Anemia	rare	occasional	often
Frequent Nose Bleeds	rare	occasional	often
Dull Pain in Chest	rare	occasional	often

Dry Mouth	rare	occasional	often
Dry Eyes or Nose	rare	occasional	often
Flush Easily	rare	occasional	often
Thin Moist Skin	rare	occasional	often
Dry or Scaly Skin	rare	occasional	often
Course Hair	rare	occasional	often
Tendency to Hives	rare	occasional	often
Brown Spots on Skin	rare	occasional	often
Itching Skin or Feet	rare	occasional	often
Loss of Hair	rare	occasional	often
Frequent Skin Rashes	rare	occasional	often

Cold Sweats Often	rare	occasional	often
Excessive Body Odor	rare	occasional	often
Watery Nose or Eyes	rare	occasional	often
Swollen or Puffy Eye Lids	rare	occasional	often
Hoarseness of Voice	rare	occasional	often
Slow to Get Going	rare	occasional	often
Sensitivity to Cold (Chill Easily)	rare	occasional	often
Insomnia	rare	occasional	often
Heat Intolerance	rare	occasional	often
Fatigue Easily	rare	occasional	often
Sleepy During Day	rare	occasional	often
Hot Flashes	rare	occasional	often

Morning Joint Stiffness	rare	occasional	often
Muscle Cramps (Charlie Horse)	rare	occasional	often
Restless Legs	rare	occasional	often
Joint Pain	rare	occasional	often
Burning Feet	rare	occasional	often

Unusual Sweet Cravings	rare	occasional	often
Awaken after a few hours of sleep	rare	occasional	often
Sigh Frequently	rare	occasional	often
Highly Emotional	rare	occasional	often
Easily enraged	rare	occasional	often
Mental Sluggishness	rare	occasional	often
Reduced Initiative	rare	occasional	often

Frequent Colds or Flu	rare	occasional	often
Frequent Asthma or Bronchitis	rare	occasional	often
Bruise Easily	rare	occasional	often
Frequent Urination	rare	occasional	often
Wounds Heal Slowly	rare	occasional	often

IMPORTANT

Please list below your five (5) greatest health concerns in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____

Please tell us briefly how you heard about our clinic:
