General Intake Form

PLEASE do not wear any scents such as perfumes or aftershaves to the office, as some patients are allergic. Thank you.

General Information:

Name:________________________ Sex: M F Marital Status:____________

Address:____ Postal Code:________

Phone: Home:______________ Work:____________________ Email:____________

Birth Date:____________ Occupation: ____________________ #Children:____

Next of kin:____________________ Phone #:____________________

Name / address of present physician____________________________________

____

Who referred you, or how did you learn of us?___________________________

Height:______ Current weight:______ Lowest adult weight:_______ Highest:________

Please describe your major concerns and/or symptoms. Please be clear and concise to help us help you. Include when the symptoms first began. Write what you can in the space provided. If you need more space, add a separate piece of paper.______________________________

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If you have seen other physicians for these concerns, indicate the results of these evaluations:________

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Please bring medical records, if possible, especially lab tests or hospital discharge summaries.

What habits, activities or attitudes do you consider to have contributed to any of your concerns?______

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Are you currently receiving psychiatric care or undergoing psychological counseling? **Y N**

Health History*:* Please indicate if you have any of the following conditions (please circle):

Kidney disease	*Diabetes*	*Migraines*	*Headaches*	*Hypoglycemia*	*Breast feeding*
Stroke	*Depression*	*Asthma*	*Gout*	*Cancer*	*Skin condition*
Allergies	*Lung disease*	*Anemia*	*Arthritis*	*Fainting*	*Mental illness*
Hemorrhoids	*Fibromyalgia*	*Acne*	*Anorexia*	*Anxiety*	*Bloating/gas*
Indigestion	*Bronchitis*	*Cold sores*	*Constipation*	*Dandruff*	*Diarrhea*
Weight gain	*Weight loss*	*Emphysema*	*Fainting*	*Hair loss*	*Heartburn*
Herpes	*Hot flashes*	*Insomnia*	*HIV*	*Kidney stones*	*Cirrhosis*
Liver disease	*Loose stools*	*Poor memory*	*Confusion*	*Panic attacks*	*Ulcer*
Incontinence	*Hearing loss*	*Respiratory problems*		*Suicidal tendencies*	
Pneumonia		*Poor nail growth*		*Gallbladder removed*	
Thyroid problems		*High cholesterol*		*Addiction (drugs/alcohol)*	
Chronic Fatigue Syndrome		*Intestinal problems*		*Chronic cold or flu symptoms*	
Bladder infections		*Viral or bacterial disease*		*High blood pressure*	
Ringing in the ears		*Neurological disease*		*Irregular menstruation*	
Painful menstruation		*Loss of menstruation*		*Painful Intercourse*	
Menopause		*Endometriosis*		*Infertility*	
Other					

Please list any **previous** illnesses, accidents and hospitalizations you have had: Please include dates:______
____
____
____

Please list medications, vitamins, minerals and supplements you are presently taking:
____
____
____
____

Do you have allergies or sensitivities to any medications (name of drug and type of reaction)?
____
____

MEDICAL HISTORY: Please indicate which of the following conditions you or your family (parents, siblings, aunts, uncles, grandparents, etc.) have: (Beside each condition specify who including yourself.)

Alcoholism ______________________
Allergies ______________________
Arthritis ______________________
Anemia ______________________
Angina ______________________
Asthma ______________________
Bleeding/Bruising ______________________
Cancer ______________________
Convulsions/Epilepsy ______________________
Crohn's Disease/Colitis ______________________
Diabetes ______________________
Digestive Disorders ______________________
Herpes/Shingles______________________
Hypoglycemia ______________________
Drug Problems ______________________
Eczema/Psoriasis ______________________
Hepatitis ______________________
High Blood Pressure ______________________
High Cholesterol ______________________
Frequent Infections ______________________
Urinary Tract Infections ______________________
Polio ______________________
Lupus ______________________
Mental Illnesses ______________________
Migraines/Headaches ______________________
Pneumonia ______________________
Prostate Problems ______________________
Sinus Problems ______________________
Strokes ______________________
Heart Attacks ______________________
Thyroid Problems ______________________
Tuberculosis ______________________
Ulcers ______________________
Weight Problems ______________________
Rheumatic Fever ______________________
Venereal Disease ______________________
Other ____

PREVIOUS MEDICAL TESTS: If known please specify date of test and results: If possible please bring most recent results to the first appointment.

Last Physical Exam ______________________
X-Rays ______________________
GI Series ______________________
Kidney/Bladder Series ______________________
Gallbladder Tests ______________________
EKG ______________________
Stress Test ______________________
Angiogram ______________________
Ultrasound Tests ______________________
Catheterization ______________________
Blood Tests ______________________
Allergy Testing ______________________
Other ____

PREVIOUS IMMUNIZATIONS: Specify when if known.

Small Pox ________________
Tetanus________________
Polio________________
Flu ________________
Mumps ________________
Measles ________________
Rubella ________________
Pneumonia ________________
Diphtheria________________
Pertussis ________________
Other____

Have you ever been on prolonged antibiotic therapy or have you used them frequently? (Ex. Erythromycin, Penicillin, Tetracycline, Sulfa Drugs, Flagyl, etc.) ______________________________

LIFESTYLE:

Do you smoke? **Y N** If yes, when did you start and how often do you smoke? ______________
Did you ever smoke? **Y N** When did you start? __________ When did you quit? ________
How long did you smoke? ______________________________________
Are you regularly exposed to second hand smoke? **Y N** Where? ____________________

Do you use recreational drugs? **Y N**
If yes, when did you start and how often do you use them? ______________________
What types of recreational drugs do you use or have you used? ____________________ _

What types of non –prescription medications do you use? (Laxatives, Antihistamines, Decongestants, Analgesics, Stimulants, etc.)______________________________________
____

Do you have any other allergies or sensitivities? (food, pollens, animals, chemicals)____________
____

Are you regularly exposed to industrial or environmental chemicals, pollution, smog or pesticides? **Y N**
If you answered yes, which ones are you exposed to? __________________________

Do you currently have any pets? **Y N**

Describe the emotional climate of your home/work? __________________________
____
____

What do you do to relax? (Ex. Hobbies) ______________________________
____
____

Do you exercise regularly? **Y N**
How often do you exercise? ______________ Length of session? ____________
What type of exercise do you do? ______________________________

Describe your home life as a child: (please circle all appropriate terms)
Loving Supportive Stressful Abusive Peaceful Loud Argumentative Educational Alcoholic Friendly Single Parent Lonely Other ______________________________

Circle the following illnesses you had as a child?
Colic Eczema Asthma Polio Allergies Bronchitis Pneumonia Meningitis Rheumatic Fever Recurrent colds Ear infections Thrush German Measles Bedwetting Tonsillectomy Persistent Diaper Rash Learning Disability Hyperactivity Other ______________________________

Have you ever traveled out of the Country? **Y N** Have you ever had Traveler's Diarrhea? **Y N**
Have you ever been treated for parasites? **Y N** Have you ever been tested for intestinal parasites? **Y N**

How much sleep do you get per night? ______________________________
How often do you have a bowel movement? ____________________________