INTAKE FORM - I

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New Client Intake Form (Please print or write clearly) Date _____

Name_____ Home Phone _____

Address _____ Cell Phone _____

City _____State ___ ZIP _____ Work Phone _____

Occupation _____ Birthdate ___/___/_____ Age _____ Sex _____

Height _____ Weight _____ Referred by _____

In case of emergency notify _____

Relationship _____

Their Home Phone _____ Work Phone_____ Cell Phone_____

Physician _____ Physician's Phone _____

Physician Address _____
Street City State ZIP code

Reason for today's visit? _____
_____
_____
_____
_____
_____

How long have you had this condition? _____ Have you had it in the past? _____
If "yes" in the past, describe when _____
What makes it better? _____
What makes it worse? _____
Is your condition… getting worse___ getting better___ constant___ comes and goes___
If applicable, circle a number to indicate your level of difficulty.
Minimal = 1 2 3 4 5 6 7 8 9 10 = Extreme

If you have a diagnosis, what is it? _____
Diagnosing physician _____
Are any other practitioners treating this condition? Y / N _____
Are you under the care of another physician for any other problems? (List problem and physician) _____
_____

What kinds of treatments have you tried? _____
_____

What was occurring in your life when your difficulties began? _____

_____

Please describe any important events occurring at that time or since then that may have started the difficulties of that contribute to them _____

_____

Please list all medications, hormones, laxatives, herbs, homeopathics and supplements you are taking and for what reason _____

_____

_____

Please list allergies to any medications _____

_____

Medical History

Date of your last physical exam _____ By whom? _____
List surgeries and dates _____

_____

Significant accidents, hospitalizations and traumas with dates: _____

_____-

_____

Do you or have you ever had (circle and mark year):

AIDS, ARC or HIV	Kidney or bladder trouble	Cancer
Dyslexia	Thyroid problems	Hepatitis
IDADHD	Hemophilia	Liver disease
Sexually transmitted disease	Rheumatic fever	Scarlet Fever
Epilepsy	Polio	Ulcer
Gallstones	Scarlet fever	Depression
Sudden weight loss	Neuralgia	Anxiety
Blood transfusions	Hemorrhoids	Emphysema
Mononucleosis	Malaria	Pneumonia
Arthritis	Yellow jaundice	Eczema
High blood pressure	German measles	Hives/rashes
High cholesterol	Pancreatitis	Bronchitis
Heart trouble	Tuberculosis	Diverticulosis

Have you ever taken adrenal corticosteroids (cortisone, prednisone, etc.)? Y / N _____
How long _____
How many courses of antibiotics have you had? _____
Do you have silver amalgam fillings? _____
Unusual birth history (prolonged labor, forceps delivery, C-section, etc.)? _____
Please list accidents/surgeries and location of scars _____

_____

What inoculations have you had? Tetanus (lockjaw) ___ Smallpox ___ Diphtheria ___
Poliomyelitis ___ Pertussis (whooping cough) ___ Rubella (German measles) ___
Flu ___ Other _____
What inoculations have you had in the last year? _____
Where have you traveled outside this country? _____

*** Please circle all that apply and list year when occurred ***

Family Medical History

Alcoholism	Anemia	Liver disease
Allergies/asthma	Diabetes	Stomach/ulcers
Arthritis	Epilepsy	Lung disease
Gout	Heart disease	Psychological problems
Asthma	Glaucoma	Stroke
Cancer/tumors	High blood pressure	Genetic diseases
Coronary artery disease	Kidney disease	

Musculoskeletal

Neck pain/stiffness	Mid back pain/stiffness	Leg or calf cramping
Shoulderblade pain	Low back pain/stiffness	Ankle pain/stiffness
Shoulder joint pain/stiffness	Sacroiliac pain/stiffness	Weak ankles
Upper arm pain/stiffness	Hip joint pain/stiffness	Foot or toe pain/stiffness
Elbow pain/stiffness	Pain into thigh or upper leg	Numbness or tingling in feet
Wrist pain/stiffness	Pain into calf or lower leg	Muscle spasm
Hand or finger pain/stiffness	Weak legs	Muscle weakness
Numbness or tingling in hands	Knee pain/stiffness	Paralysis
Upper back pain/stiffness	Weak knees	Stiff all over

Is the problem helped by pressure ___ heat ___ cold___ other _____

Is the problem aggravated by pressure ___ heat ___ cold___ other _____

Gastrointestinal

Constipation	Black stool	Stomach acidity
Hard stools	Hemorrhoids	Indigestion
Bowel movements feel incomplete	Colitis	Gurgling noise in stomach
	Diverticulitis	Bad breath
Frequent laxative use	Parasites	Excessive appetite
Diarrhea	Abdominal bloating	Poor appetite
Loose stools	Gas (flatulence)	Excessive thirst
Erratic bowel movements	Mucous in stool	Nausea
Fowl smelling stools	Hiatal hernia	Vomiting
Undigested food in stool	Lower abdominal pain/cramping	Bloated
Gained/lost more than 10 pounds		Belching
	Upper abdominal pain/cramping	Ulcer
Blood in stool		Difficulty swallowing

How often do you have a bowel movement? _____

Cardiovascular

High blood pressure	Coronary heart disease	Edema
Low blood pressure	High cholesterol	Swelling of hands
Blackouts or fainting	Stroke	Swelling of feet
Irregular heartbeat	Blood clot	Cold hands
Heart valve problem/murmur	Phlebitis	Cold feet
Rapid heartbeat/palpitations	Leg cramps	Hot hands of palms
Dizzy spells	Varicose veins	Hot feet or soles
Shortness of breath	Bruise easily	Generally too hot
Angina or chest pain	Anemia	Generally too cold

Skin and Hair

Rashes
Hives
Itching
Burning skin
Eczema
Psoriasis
Bruise easily
Bleed easily
Herpes Zoster (shingles)
Boils
Pimples or acne
Ulcerations or sores
Recent moles
Recent change in mole
Warts
Dry skin
Moist feet
Moist palms
Fungus on skin
Fungus under nails
Weak or brittle nails
Loss of hair
Dandruff

Any numb areas? _____ Where? _____

Eyes

Nearsighted (myopia)
Farsighted (hyperopia)
Astigmatism
Glaucoma
Cataracts
See halo
See double
Night blindness
Sensitivity to light
Blurred vision
Floating spots
Pressure behind eyes
Eye pain
Dry eyes
Watery eyes
Itchy eyes
Red eyes
Conjunctivitis
Use eyeglasses or contacts
Blindness
Eye infections

Sleep

Difficulty falling asleep, wired
Shallow sleep
Dream disturbed sleep
Nightmares
Wake at night—thinking
Wake at night—mind empty, eyes open
Snoring
Difficulty waking in a.m.
Wake up unrefreshed
Sleepy in afternoon
Need to take naps
Sleep too much
Sleep too little
Sleep on a waterbed
Sleep with an electric blanket

How many hours do you sleep in a 24-hour period? _____

Urinary and Genital

Scanty or small amount of urine
Dark urine
Strong smelling urine
Cloudy urine
Profuse or large amount of urine
Clear urine
Unable to hold urine
Urgency to urinate
Frequent urination
Difficulty urinating
Decreased flow of urine
Flow does not stop quickly
Dribbling
Bed wetting
Pain or burning when urinating
Pain in bladder area
Blood in urine
Bladder infection
Kidney infection
Kidney stones
Lumps on testicles
Painful testicles
Sores on genitals
Pain during intercourse
Low sexual energy
Excessive sexual energy
Inability to achieve orgasm
Prostate problems
Low sperm count
Ejaculation during sleep
Premature ejaculation
Inability to maintain erection

How often do you urinate in 24 hours? ____ How often do you wake to urinate at night? ___

Any other problems with your urinary system? _____

Pregnancy and Gynecology

Number of pregnancies
Number of births
Premature births
Miscarriages
Abortions
Difficult deliveries
Caesarean sections
Age of children
Age at first menses
Starting date of last menses
Duration of flow
Length of cycle
Age at start of menopause
Age menses stopped
Hysterectomy
  Reason for
Oophorectomy
  Reason for
Have not yet begun menstruating
Irregular flow
Clots
  dark purple
  dark brown
  red
Heavy flow
Light flow
Light colored/pale blood
Painful periods
Endometriosis
Cramping before period starts
Cramping after period starts
Low backache with period
Spotting between periods
Vaginal discharge
  no odor
  strong odor brownish
  white/curd-like
  frothy & profuse
  itchy
  burning
Missed periods
Premenstrual irritability
Premenstrual emotional
  sensitivity
Premenstrual breast
  tenderness
Premenstrual bloating
Premenstrual fluid retention
Premenstrual headache
Premenstrual constipation
Premenstrual diarrhea
Hot flashes
Abnormal pap
Uterine fibroids
Ovarian cysts
Breast cysts or lumps
Pelvic inflammatory disease
Currently have an IUD
Previously had an IUD
Current use
  of birth control pills
Previous use
  of birth control pills
Other birth control
_____
Cannot maintain pregnancy
Trying to become pregnant
Infertility
Pregnant
Nausea or morning sickness
Nursing

Any other pregnancy or gynecological problems? _____

Date of last pap test _____

Respiratory

Chronic cough
Dry cough
Tight, rattling cough
Loose cough
Thick, sticky phlegm
Thin, watery phlegm
Clear or white phlegm
Yellowish phlegm
Blood in phlegm
Bronchitis
Pneumonia
Pain with deep breath
Shortness of breath
Emphysema
Wheezing
Asthma, more difficult to exhale
Asthma, more difficult to inhale
Asthma, worse on exhaling
Frequent chest colds

Head, Ears, Nose, Mouth, Throat and Neurological

Frequent colds
Sinus congestion or pain
Facial pain
Jaw tension or clicking (TMJ)
Grinding teeth
Frequent dental cavities
Gum problems
Bleeding gums
Dentures
Dizziness or loss of balance
Convulsions
Trembles
Concussion
Seizures
Faintness
Numbness
Changes in handwriting
Headache
Migraine headache
Congestion in ears
Earache
Ringing in ears
Difficulty hearing
Motion sickness
Deafness
Nasal congestion
Runny nose
Nose bleeds
Sneezing
Allergies

Decreased sense of smell
Dry mouth
Excessive saliva or drooling
Taste in mouth
Taste changes
Sores on tongue
Sores in mouth (canker)
Sores of lips (fever blister)
Difficulty swallowing
Lump or pit in throat
Sore throat
Strep throat
Swollen lymph nodes
Tonsillitis

General

Head or chest cold
Flu
Recurrent fever
Chills
Night sweats
Perspire easily w/o exertion
Rarely perspire
Jaundice
Armpits or groin swellings
Anemia
Always fatigued
Fatigued easily
Sudden drop in energy
Recreational or hard drugs
Recent weigh loss
Recent weight gain
Often thirsty
Seldom thirsty
Alcohol use
Smoking

Emotional

Depression
Suicidal feelings
Frequent anger or irritation
Tendency to repress emotions
Lonely
Frightening dreams or thoughts
Sexual difficulties
Mood swings
Manic episodes
Obsessiveness or compulsiveness
Sadness or grief
Loses temper easily
Lack of concentration or memory
Worry a lot
Frequent crying
Anxiety or fear
Indecisiveness
Difficulty handling stress
Difficulty relaxing
Shy or sensitive
Desired psychiatric help

Have you ever been emotionally, physically or sexually abused? _____

Have you ever been treated for emotional problems? _____

Have you recently had any unusually stressful experiences (divorce, death of a loved one, bankruptcy, loss of a job, illness, injury, etc.)? Describe. _____
_____
_____
_____

Is there a constant stress in your life, at work, with your family, etc. _____
_____
_____

Any other emotional problems? _____
_____
_____

Emotions

1. Anger/frustration. Can you express your anger? Are you often on edge and do you anger easily, or are you more prone to have difficulties expressing feelings of anger? Describe briefly. _____
_____

2. Joy. Do you laugh often at inappropriate moments or laugh very frequently? Or do you tend to have difficulty expressing joy and laughter? Describe briefly. _____
_____
_____

3. Sympathy. Do you tend to look for sympathy form others when faced with problems or pain, or are you unable to accept sympathy? Do you tend to be overly sympathetic or compassionate with others, or is the opposite true? Describe briefly. _____
_____
_____

4. Grief. Can you cry? Do you have difficulty crying regardless of the situation, or do you cry at the simplest things? Do you grieve easily, or is it difficult? Describe briefly.
_____
_____

5. Fear. Do you frighten easily, or it difficult for you to experience fear? Describe briefly. _____
_____

Family / Relations

At birth (health, difficulties, family stressors and expectations) _____
_____

Childhood/adolescence stressors or difficulties (describe) _____
_____

Quality of intimate relationships or marriage. Please describe. _____
_____

Friendships (social life). Is it easy to make friends and keep them, or is it difficult? Describe.
_____
_____

Present relationships with siblings and parents (describe) _____
_____

Schedules / Habits / Interests

Sleep schedule and quality of sleep (describe) _____
_____

Nutrition and eating, regularity and habits, for example, eating on the run or taking time to eat and enjoy food (describe) _____
_____

Work life (satisfaction, goals, stresses, etc.). Describe. _____

_____

Sexual life (enjoyment, frequency, difficulties, etc.). Describe. _____
_____

Intellectual interests (describe) _____
_____

Exercise/self-care (describe) _____
_____

What I enjoy the most (describe) _____
_____

Spirituality/religion (life purpose or life mission, goals, satisfaction, etc.). Describe.
_____
_____

How I view myself (lovability, self-worth, assertiveness, power, etc.). Strengths and limitations. Describe. _____
_____
_____

Expectations Regarding Treatment

In a few words, what do you think treatment is all about? _____
_____

How long do you think it should last? _____

How do you think a practitioner should interact with his/her clients? What are the ideal qualities he/she should possess? _____
_____

What are your expectations and hopes in coming here? _____
_____
_____

Can you put these in terms of specific behavior changes? For example, "I want to stop doing…," or "I want to start doing…." _____
_____
_____

How would you know that these changes had happened? _____
_____

What is your sense of what would need to happen for these changes to occur? What obstacles might there be? _____
_____
_____

What reactions do you think these changes will cause in important others? _____
_____
_____