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 \_\_\_\_\_

Reason for today’s visit? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What kinds of treatments have you tried? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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What was occurring in your life when your difficulties began? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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Please list allergies to any medications \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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# Medical History

Date of your last physical exam \_\_\_\_\_\_\_\_\_\_ By whom? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List surgeries and dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Significant accidents, hospitalizations and traumas with dates: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

AIDS, ARC or HIV

Dyslexia

IDADHD

Sexually transmitted disease

Epilepsy

Gallstones

Sudden weight loss

Blood transfusions

Mononucleosis

Arthritis

High blood pressure

High cholesterol

Heart trouble

Kidney or bladder trouble

Thyroid problems

Hemophilia

Rheumatic fever

Polio

Scarlet fever

Neuralgia

Hemorrhoids

Malaria

Yellow jaundice

German measles

Pancreatitis

Tuberculosis

Cancer

Hepatitis

Liver disease

Scarlet Fever

Ulcer

Depression

Anxiety

­­­­­­Emphysema

Pneumonia

Eczema

Hives/rashes

Bronchitis

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 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

Allergies/asthma

Arthritis

Gout

Asthma

Cancer/tumors

Coronary artery disease

Anemia

Diabetes

Epilepsy

Heart disease

Glaucoma

High blood pressure

Kidney disease

Liver disease

Stomach/ulcers

Lung disease

Psychological problems

Stroke

Genetic diseases

# Musculoskeletal

Neck pain/stiffness

Shoulder blade pain

Shoulder joint pain/stiffness

Upper arm pain/stiffness

Elbow pain/stiffness

Wrist pain/stiffness

Hand or finger pain/stiffness

Numbness or tingling in hands

Upper back pain/stiffness

Mid back pain/stiffness

Low back pain/stiffness

Sacroiliac pain/stiffness

Hip joint pain/stiffness

Pain into thigh or upper leg

Pain into calf or lower leg

Weak legs

Knee pain/stiffness

Weak knees

Leg or calf cramping

Ankle pain/stiffness

Weak ankles

Foot or toe pain/stiffness

Numbness or tingling in feet

Muscle spasm

Muscle weakness

Paralysis

Stiff all over

Is the problem helped by pressure \_\_\_ heat \_\_\_ cold\_\_\_ other ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is the problem aggravated by pressure \_\_\_ heat \_\_\_ cold\_\_\_ other ­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

### **Gastrointestinal**

Constipation

Hard stools

Bowel movements feel incomplete

Frequent laxative use

Diarrhea

Loose stools

Erratic bowel movements

Fowl smelling stools

Undigested food in stool

Gained/lost more than

10 pounds

Blood in stool

Black stool

Hemorrhoids

Colitis

Diverticulitis

Parasites

Abdominal bloating

Gas (flatulence)

Mucous in stool

Hiatal hernia

Lower abdominal pain/cramping

Upper abdominal pain/cramping

Stomach acidity

Indigestion

Gurgling noise in stomach

Bad breath

Excessive appetite

Poor appetite

Excessive thirst

Nausea

Vomiting

Bloated

Belching

Ulcer

Difficulty swallowing

### How often do you have a bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_

### **Cardiovascular**

### High blood pressure

Low blood pressure

Blackouts or fainting

Irregular heartbeat

Heart valve problem/murmur

Rapid heartbeat/palpitations

Dizzy spells

Shortness of breath

Angina or chest pain

Coronary heart disease

High cholesterol

Stroke

Blood clot

Phlebitis

Leg cramps

Varicose veins

Bruise easily

Anemia

Edema

Swelling of hands

Swelling of feet

Cold hands

Cold feet

Hot hands of palms

Hot feet or soles

Generally too hot

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. ­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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Any other emotional problems? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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By entering my name, this is my electronic signature for consent.