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New Patient Intake Form

Name_____ Today's date_____

Address_____

Phone (home)_____ Phone (work or cell)_____

Birth date_____ Age_____ Occupation_____

Emergency contact_____ Phone _____

Are you currently under the care of a physician? Who ?_____

How did you hear about this clinic?_____

What is your main complaint?_____

Do you have a diagnosis?_____

How long has this problem been troubling you?_____ What types of treatment have you tried for this problem?_____

What were the results of the treatment?_____

Please list other complaints in order of importance:

1)_____ length of time _____

2)_____ length of time_____

3)_____ length of time_____

4)_____ length of time _____

Please list current medications, supplements, homeopathics or herbs taken:_____

_____

Please list surgeries, traumas or hospitalizations and dates: _____

_____

Please check childhood illnesses you have had:

____ chicken pox ____ mumps ____ rubella (German measles)

____ diphtheria ____rheumatic fever ____ scarlet fever

____ polio ____ tetanus ____whooping cough _____other

Please check any of the following conditions you may have had and give the date of diagnosis:

____AIDS/HIV ____allergies ____anemia ____asthma ____cancer ____cirrhosis ____diabetes

____eczema ____heart attack ____heart disease ____hemophilia ____hepatitis ____herpes

____high blood pressure ____infections ____mononucleosis ____ osteoporosis _____ pneumonia

____seizures ____stroke ____thyroid ____tuberculosis _____venereal disease ____weight problem

____anxiety disorders ____depression ____sexual/physical abuse ____suicidal thoughts

Other conditions we should know about?_____

Please describe what you eat on a typical day or what you ate yesterday:

Breakfast_____

Lunch_____

Snacks_____

Dinner_____

What, if any ,is your exercise routine?_____

_____

Please list any significant family (near or distant) health history:

_____

_____

_____

Signature_____

Date_____