New Patient Intake Form

Please fill out this New Patient Intake Form as best as you can with all information about yourself so the information will provide me with the best Holistic care I can provide for you.

Primary Information

Please fill out this section regarding a very basic Medical inquire.

Full Name *

Address

City

State

Alabama

Zip

Birth Date

-MM- / -DD- / -YYYY-

Age

Email *

Cell Phone *

Work Phone

Height

weight

1 Year Ago

5 Years Ago

Occupation

Hours Of Employment

- [ ] Full Time
- [ ] Part Time

Living Situation

- [ ] Alone
- [ ] Partner
- [ ] Parents

- [ ] **Pets**
- [ ] **Friends**
- [ ] **Spouse**
- [ ] **Children**

Basic Medical Information

Please fill out this section regarding a very basic Medical inquire.

What are your major health concerns and intentions for your visit today?

Please list any other health care providers or consultants you are currently working with:

Please list any current health conditions diagnosed by a medical doctor:

When was the last time you had a physical exam?

-MM- / -DD- / -YYYY-

Please list al herbs,vitamins, and dietary supplements you are curently taking, including dosage and frequency:

List all medications you are currently taking indicating whether they are over the counter (OTC) or

Prescription, including dosage and frequency:

List all medications, herbs, foods, environmental factors, and any other reasons to which you have a known allergy:

Dietary Information

Describe below your typical meals. Please be specific as possible. For example, instead of "oil" note type of oil, such as olive, corn, etc. Instead of "bread" list whether white or whole grain etc. Instead of "vegetables" list the type of vegetable, how prepared, canned, frozen, or fresh, etc. Please include all beverages, type and quantity (two cups of orange juice, one cup of coffee, etc.).

Breakfast:

Morning snack(s):

Lunch:

Afternoon Snack(s):

Dinner:

Daily filtered or spring water consumption (number of glasses/day):

Any recurring food cravings (such as salt, starch, sugar, chocolate, etc.) Please list as many as applicable including time of day or month:

Family History

Please describe any relevant or major health related issues: (cancer, mental illness, diabetes, heart disease, etc.)

Mother:

Father:

Sister(s):

Brother(s):

Maternal Grandmother:

Maternal Grandfather:

Paternal Grandmother:

Paternal Grandfather:

Medical History

Describe all major health problems including any operations:

Problem and year?

General Health

Please check all that apply.

Cardiovascular

- ☐ **High blood pressure**
- ☐ **Low blood pressure**
- ☐ **Pain in heart**
- ☐ **Poor circulation**
- ☐ **Swelling**
- ☐ **Stroke/Murmur**

Skin

- ☐ **Boils**
- ☐ **Bruises**
- ☐ **Dryness**
- ☐ **Itching**
- ☐ **Varicose Veins**
- ☐ **Skin Eruptions**

Muscles/Joints

- ☐ **Backache**
- ☐ **Broken Bones**
- ☐ **Limited Mobility**
- ☐ **Arthritis**
- ☐ **Bursitis**
- ☐ **Weakness**

Respiratory

- ☐ **Chest Pain**
- ☐ **Difficulty Breathing**
- ☐ **Cough**
- ☐ **Tuberculosis**
- ☐ **Congestion**
- ☐ **Itchy Eyes/Ears**
- ☐ **Asthma**

- [ ] **Coughing Up Blood**

Urinary/Kidney

- [ ] **Excessive Urination**
- [ ] **Water Retention**
- [ ] **Burning Urine**
- [ ] **Kidney Stones**
- [ ] **Lower Back Pain**
- [ ] **Wheezing**
- [ ] **Circles under Eyes**
- [ ] **Blood In Urine**

Gastro-Intestinal

- [ ] **Belching**
- [ ] **Colitis**
- [ ] **Constipation**
- [ ] **Abdominal Pain**
- [ ] **Liver Disorders**
- [ ] **Gallstones**
- [ ] **Ulcers**
- [ ] **Digestive Troubles**

General

- [ ] **Fatigue**
- [ ] **Night Sweats**
- [ ] **Fever**
- [ ] **Excessive Thirst**
- [ ] **Loss Of Appetite**
- [ ] **Always Hungry**
- [ ] **Difficulty Sleeping**
- [ ] **Irritability**
- [ ] **Cold Hands And Feet**

Male Reproductive

- [ ] **Burning/Discharge**
- [ ] **Swelling Of Testicles**
- [ ] **Painful Testicles**

- [ ] Vasectomy
- [ ] Genital Herpes

Female Reproductive

- [ ] Heavy Bleeding
- [ ] Breast Pain
- [ ] Irregular Cycles
- [ ] Vaginal Dryness
- [ ] PMS
- [ ] Pain/Cramps
- [ ] Hot Flashes
- [ ] Vaginal Discharge
- [ ] Infertility
- [ ] Blot Clots
- [ ] Breast Lumps
- [ ] Pre-Menopausal
- [ ] Pelvic Pain
- [ ] Unable To Conceive
- [ ] Painful Intercourse
- [ ] Mood Swings
- [ ] Vaginal Iching
- [ ] Genital Herpes
- [ ] Menopause
- [ ] Anemia

Contraceptive History

- [ ] Oral Contraceptives
- [ ] Rhythm-Method
- [ ] I.U.D.
- [ ] Diaphragm
- [ ] Condoms
- [ ] Mucous-Method
- [ ] Cervical Cap
- [ ] Spermicides
- [ ] Fertility Lens

Your Blood Type?

Please list each pregnancy you have had, including miscarriages

Current state of Emotions and Spiritual Well-Being

Please click all those that describe you:

Please list approximent dates and describe the nature of any traumatic experiences you have had in the past 7 years (Divorce, surgery, end of a relationship, loss of job, change of residence, injury, death of a loved one including pets, etc.)

Do you engage in regular physical activity?

- ◯ **Yes**
- ◯ **No**

If yes, for how many mins?

How often?

Do you drink coffee and/or caffinated drinks?

- ◯ **Yes**
- ◯ **No**

If yes, how much?

How often?

Do you drink alcohol?

- ◯ Yes
- ◯ No

If yes, how much

How often?

Do you smoke tobacco?

- ◯ Yes
- ◯ No

If yes, how many per day?

Do you use artificial sweeteners?

- ◯ Yes
- ◯ No

How many hours of TV do you watch in a week?

Please use this space to add any other information about yourself that you think will be helpful: