

**PATIENT INTAKE FORM INCLUDING WESTERN AND MERIDIAN BASED PERSONAL AND FAMILY
MEDICAL HISTORY AND PATIENT CURRENT HEALTH CONDITION AND COMPLAINT**

(This comprehensive medical history gives us a complete picture of your health. We provide this questionnaire prior to your visit so you will have time to answer all questions. Please bring the completed form to your first visit.)

Name _____ Date of first appointment _____

Age ____ M / F Date of birth (and time, if known) _____ Birthplace _____

SSN: _____ - _____ - _____

Email Address _____

Address _____

Telephone # (h) _____ - _____ (w) _____ - _____ (m) _____

Occupation _____ Hours per week _____

Education (last grade completed) _____ Marital status _____

Emergency contact _____ Phone # _____

How did you hear about us? _____

Current healthcare provider, if any _____

Date of last complete physical _____

Weight _____ One year ago _____ Maximum _____ When? _____

Height _____

What is your normal blood pressure? _____

Primary health concern:

How seriously do you feel this health concern negatively affects your life, on a Scale of 1 to 10, with 10 being severe.

How committed are you to getting rid of this problemn, a Scale of 1 to 10, with 10 being 100% committed.

Other concerns (list as many as you like, in order of importance to you):

GENERAL INFORMATION AND PAST MEDICAL HISTORY

FAMILY HISTORY

MOTHER FATHER BROTHERS SISTERS PARTNER CHILDREN

Age
(or age of death)

Current Health
(or cause of death)

MARK AN INITIAL (C, M, F, B, S, Sp/P) FOR ALL CATEGORIES BELOW THAT ARE APPLICABLE, PAST OR PRESENT

CHILDREN MOTHER FATHER BROTHERS SISTERS PARTNER /SPOUSE

_____ Cancer _____ Diabetes _____ Heart disease
_____ Hi blood pressure _____ Stroke _____ Epilepsy
_____ Mental illness _____ Asthma _____ Allergies
_____ Skin diseases _____ Anemia _____ Kidney disease
_____ Glaucoma _____ TB, HIV, HPV, Hep _____ Ulcer/colitis
_____ Thyroid disease _____ Autoimmune Diseases (what?)

PATIENT HISTORY

HOSPITALIZATIONS AND SURGERIES (begin with the most recent; remember to include hysterectomies, vasectomies, etc)

ABNORMAL LAB TESTS, ultrasound, MRI, etc.

ALLERGIES

Drugs _____

Foods _____

How were you tested? _____

CURRENT MEDICAL DIAGNOSES, if any _____

CURRENT MEDICATIONS (please list all prescription, non-prescription, and dietary supplements, including herbs; include dosage where possible)

TYPICAL DIET

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Cravings (sweet, salty, sour, bitter, spicy, other) _____

EXERCISE and HABITS (describe: type and amount; habits: alcohol, drugs, smoking, sweets, cheese etc.)

LIFETIME REVIEW OF ILLNESSES (LIST, but DO NOT describe, all serious physical or emotional complaints that you have suffered; it is helpful to begin with the most recent complaints):

Psychological/Emotional

Musculoskeletal

Skin

Head (describe: pain, discomfort, discharge, include eyes, ears, nose, throat)

Lungs/Infections

Heart and blood vessels

Stomach and bowels

Urinary/reproduction

Communicable diseases (TB, Hepatitis, Sexually Transmitted Diseases, HIV, AIDS, other)

CURRENT HEALTH STATUS

CHIEF COMPLAINT (description, previous therapies):

WHEN DID IT START and DO YOU KNOW WHY?

WHAT MAKES IT BETTER AND WORSE? (ex: heat, cold, foods, pressure, bending, positioning)

WHAT IS THE QUALITY OR TYPE OF SENSATION OR PAIN (DESCRIBE)? (ex: achey, burning, fixed, moveable, colicky, sharp, deep)

DOES IT RADIATE TO OTHER AREAS OF THE BODY?

IS IT MILD OR SEVERE?

IS IT CONSTANT OR INTERMITTENT?

OTHER COMPLAINTS:

PATIENT HEALTH STATUS (CONT)

MENTAL (how is your memory and concentration?)

EMOTIONAL (describe:are you happy with money, work, family? How is your emotional state?):

STRENGTH/IMMUNITY (describe: your energy level; do you get frequent colds and flus,allergies?):

SLEEP (describe:do you sleep well, easy to fall asleep, wake refreshed? Restless, dream disturbed?):

TEMPERATURE (describe:prefer hot or cool weather; do you sweat easily; do you have nightsweats?):

SKIN (describe:lumps, bruising, rashes, varicisoties, swellings, itching, discolorations):

MUSCULOSKEL (describe:pain, numb, tingle, paralysis, weakness, spasms, stiffness):

Headache & DIZZINESS (describe: pain, balance, vertigo, seizures):

Eyes, Ears, Nose, Throat (describe: itchy, dry, tearing, pain, discharge,burning) :

CARDIAC (describe: pain, palpitations, murmurs, edema):

RESPIRATORY (describe: cough, Shortness of Breath, wheezing, sputum, asthma, allergies, hay fever):

APPETITE/DIGESTION (describe:a good appetite? any problems with digestion like gas, bloating, belching, heartburn, nausea, vomiting, hunger, pain? Food intake):

ELIMINATION (describe: daily bowel movements? Normal is well formed, brown, mild smell, 1-3x/day; any problems with constipation, diarrhea, loose stool, undigested food in the stool, sticky, pain, blood in the stool):

THIRST/DRYNESS (describe: are you thirsty or not thirsty? do you have problems with dry hair, skin, stool or other):

URINATION (describe: frequency, is there any irritation, strong smell or difficulty? do you have inontinence or wake at night to urinate)

MALE (describe: problems with sexual desire, sensation, performance, discharge, lesions, infections, prostate, lumps, swellings, herniations, pain):

Describe any problems with sexual desire, sensation, performance, orgasm:

Add any additional information you think may be relevant:

FEMALE :

Menarche (date/age of beginning of menses) _____ Menopause _____ Cycle Length

Duration of bleeding (in days) _____ Quality (describe:color, pain, clots, flow) _____

PMS (describe) _____

Menopause (describe)

Last PAP _____ Ever Abnormal _____

Discharge _____

Birth control/ Disease prevention Methods _____

Pregnancies _____ Births _____ Abortion _____ Miscarriage _____

Complications _____

Describe any problems with sexual desire, sensation, performance, orgasm:

Add any additional information you think may be relevant: