Intake Form

Information provided in this form is confidential. It is important that the information given is complete and accurate to help you properly in your healing process.

Today's Date ___/___/___ Name _____

Date of Birth ___/___/___ Age _____ Sex _____

Address _____

City / State / Zip _____

Email _____ Telephone (home) _____

(work) _____ (cell) _____

How did you hear about us?

_____

Main goals you would like help with:

1. _____

2. _____

3. _____

List any prescription medications, herbs, vitamins, or other supplements you are currently taking

_____

_____

Significant trauma, hospitalizations, surgery (please include accidents, falls, illness with month/year)

_____

_____

Past treatments (please indicate any forms of past treatment, both conventional and alternative)

_____

Allergies: Are you hypersensitive or allergic to any foods, drugs, chemicals, or environmental substances?

_____

_____

Describe your daily physical exercise

_____

Check (✔) any conditions you currently experience. Star (☆) those you've had in the past.

GENERAL

____ Poor or Change in Appetite
____ Poor Sleep
____ Fatigue / Low Energy
____ Fevers
____ Chills
____ Cravings
____ Bleed/Bruise Easily
____ Night Sweats or Hot flashes
____ Sweat Easily
____ Colder than those around you
____ Warmer than those around you
____ Weight loss or gain
____ Libido Low, Med or High
____ High Stress

NOSE AND SINUSES

____ Frequent Colds
____ Nose Bleeds
____ Sinus Congestion
____ Frequent Runny Nose
____ Hay Fever
____ Sinus Problems
____ Loss of Smell

IMMUNE

____ Chronic Fatigue Syndrome
____ Chronic Infections
____ Chronically Swollen Glands
____ Slow Wound Healing
____ Recurrent Colds

HEAD / NECK

____ Headaches
____ Migraines
____ Jaw Pain
____ Teeth Grinding
____ Swollen Glands
____ Goiter
____ Recurrent Sore Throats

SKIN

____ Rashes
____ Eczema or Psoriasis
____ Acne, Boils
____ Redness of Skin
____ Itching
____ Fungal Infections
____ Skin Discoloration
____ Hair Loss
____ Dry Skin/Scalp
____ Greasy Hair
____ Change in Hair texture
____ Night Sweats
____ Slow healing ulcerations
____ Weak or ridged nails
____ Recent Moles

MOUTH AND THROAT

____ Sore Throat
____ Copious Saliva
____ Teeth Grinding
____ Sore Tongue/Lips
____ Gum Problems
____ Hoarseness

RESPIRATORY

____ Chest Congestion
____ Chest Tightness
____ Asthma
____ Difficulty inhale/exhale
____ Phlegm...what color ?
____ Cough ___ Wet or ___ Dry
____ Coughing Blood
____ Bronchitis
____ Pneumonia

NEUROLOGICAL

____ Seizures or Tremors
____ Paralysis
____ Muscle Weakness
____ Numbness or tingling
____ Easily Stressed
____ Vertigo or Dizziness
____ Loss of Balance

CARDIOVASCULAR

____ Chest Pain or Pressure
____ Shortness of Breath
____ Irregular Heart Beat
____ Palpitations at Rest
____ Blood Clots
____ Irregular Heart Beat
____ Palpitations/ Fluttering
____ Swelling of Hands or Feet

EYES AND EARS

____ Itchy Eyes
____ Watery Eyes
____ Dry Eyes
____ Swollen/painful eyes
____ Red Eyes
____ Blurred Vision
____ Spots in Front of Eyes
____ Cataracts
____ Color Blindness
____ Double Vision
____ Glaucoma
____ Hearing Difficulty
____ Ringing
____ Earaches/ Infection

DIGESTION

____ Abdominal Pain/Cramps
____ Trouble Swallowing
____ Heartburn/Acid Reflux
____ Change in Appetite/Thirst
____ Nausea
____ Vomiting
____ Gas/Bloating
____ Belching or Passing Gas
____ Diarrhea
____ Constipation
____ Pain or Cramps
____ Mucous in Stools
____ Black/Bloody Stool
____ Hemorrhoids
____ Itchy/Burning Anus
____ Bad Breath
____ Strong Smelling Stools
____ Food in Stools
____ IBS
____ Crohns

Bowel Movements :
How Often ? ____
Stools ___ Hard ___ Firm
___ Soft ___ Loose (> 2 / day)

CIRCULATION

____ Faintness
____ Dizziness
____ Easy Bleeding or Bruising
____ Anemia
____ Deep Leg Pain
____ Varicose Veins
____ Cold hands/feet
____ Spontaneous Sweating

ENDOCRINE

_____ Hypothyroid
_____ Heat or Cold Intolerance
_____ Hypoglycemia
_____ Diabetes
_____ Excessive Thirst
_____ Excessive Hunger
_____ Seasonal Depression

MUSCLE / JOINT / BONES

____ Neck Pain
____ Jaw Pain
____ Shoulder Pain
____ Arm/Wrist Pain
____ Knee Pain
____ Back Pain: Low Middle Upper
____ Sciatica
____ Heaviness of Limbs
____ Muscle Pain/Tension
____ Muscle spasms / cramps
____ Restless Leg Syndrome
____ Weak/Sore Lower Body
____ Areas of Numbness
____ Loss of Strength
____ Tingling Sensations

GENITO-URINARY

____ Pain/Burning when urinating ____ Frequent Urination
____ Dark or Pale Yellow
____ Cloudy Urine
____ Night Urination
____ Copious or Scanty Urination
____ Inability to hold Urine
____ Urinary Tract Infections
____ Kidney Stones
____ Blood in Urine

MENTAL / EMOTIONAL

____ Mood Swings
____ Anxiety or Nervousness
____ Depression
____ Poor Concentration
____ Poor Memory
____ Angry Outbursts
____ Weepy
____ Sadness

FEMALES ONLY

____ Irregular Cycles
____ Bleeding between Cycles
____ Pain during Intercourse
____ Clotting
____ Heavy or Excessive Flow
____ PMS
____ Painful Menses
____ Menopausal Symptoms
____ Breast Pain / Tenderness
____ Breast Lumps
____ Ovarian Cysts
____ Endometriosis
____ Uterine Fibroids/Polyps
____ Polycystic Ovarian Syndrome

MALES ONLY

____ Hernias
____ Testicular Masses
____ Testicular Pain
____ Varicoceles
____ Premature Ejaculation
____ Prostate Disease
____ Sexual Dysfunction

Muscles, Joints, and Bones

Do have pain or tightness? _____ Where? _____

Recent injuries? _____

What type of pain (check all that apply)

___ Sharp ___ Dull ___ Aching ___ Numb ___ Superficial Pain

___ Deep ___ Burning ___ Tingling ___ Shooting ___ Pain worse/better with heat

___ Pain worse/better with cold ___ Pain worse/better with pressure

___ Pain worse in am/pm ___ Pain worse/better with movement

I have... (check all that apply)

___ Swollen joints ___ Arthritis/joint pain ___ Tendonitis

___ Bone pain ___ Muscle cramping ___ Muscle pain

___ Repetitive Strain Injury

Fractured Bone(s) - Where? _____

Pain Diagram

(please mark all areas of pain on diagram below)

A = aching B = burning N = numbness P = pins and needles

S = stabbing pain T = tightness O = other

When complete please email this form to:

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