

New Patient Intake Form

Please circle all that apply.

Indicate whether this is a current or old concern by providing an approximate date.

1. General

fever
 night sweats
 nervousness/anxiety
 bleeding
 diabetes
 thyroid
 headache
 fainting
 depression
 memory loss
 chills
 fatigue: AM/after lunch/ PM
 weight loss/gain
 anemia
 cancer
 substance abuse
 dizziness
 seizures
 phobias
 waking in night
 problems falling asleep
 hospitalizations: _____

 any broken bones, car accidents or
 other injuries? _____

2. Gastrointestinal

belching/gas
 vomiting
 bloody stools
 hernia
 constipation
 diarrhea
 abdominal pain
 nausea
 liver problems
 other _____

3. Respiratory

breathing problems
 spitting phlegm/blood
 allergies
 asthma
 shortness of breath

chronic cough
 pneumonia
 other _____

4. Cardiovascular

irregular heartbeat
 racing heart
 chest pain
 high blood pressure
 swelling
 prior heart problem
 pacemaker
 stroke
 other _____

5. Musculoskeletal

stiffness
 pain
 swelling
 spinal curve
 arthritis
 weakness
 twitching
 tremors
 numbness
 other _____

6. Skin

rashes
 mole changes
 itching
 nail changes
 redness
 other _____

7. EENT

blurry vision
 double vision
 eye pain
 jaw pain
 ringing in ears
 ear infection
 sinus problems
 nose bleeds
 throat problems
 speech problems
 glasses or contacts? _____

8. Genitourinary

frequent/painful urination
 incontinence
 blood in urine or stool
 urinary infection
 venereal infection
 other _____

9. Women Only

difficult periods
 hot flashes
 irregular cycles
 breast pain
 difficulty becoming pregnant
 complication of pregnancy
 other _____
 Date last period ended _____
 Period begins every ____ days
 Date of last gynecologic exam

10. Men Only

testicular pain
 prostate problems
 difficult erection
 low sperm count

11. Endocrine

heat/cold intolerant
 sugar cravings
 weight gain in abdomen
 problems with missing a meal
 better after meal
 thyroid problems

12. Habits

water _____ cups/day
 smoke _____ packs/day, years
 alcohol _____ drinks/week
 caffeine _____ cups/day
 recreational drug use _____

13. Family

Are your parents living? _____
 If so do you consider them to
 be in good health? _____
 Ages: Mother ____ Father _____

Circle any of the following that apply to your parents, siblings or children:

diabetes stroke hypertension cancer seizures tremors brain disorders
 heart disease lung disease arthritis scoliosis thyroid

Is the condition due to injury or sickness arising out of employment?

Is the condition due to injury or sickness arising out of an auto or other type of accident? _____

Number of days lost from work _____ Date symptoms appeared or accident happened _____

Please list all doctors you have seen related to your current concern.

- 1. _____ 2. _____
- 3. _____ 4. _____

Allergies:

What drugs are you allergic to? _____

What environmental allergies affect you? _____

What foods are you allergic to? _____

Please list any medications you have taken in the past year.

- 1. _____ 2. _____
- 3. _____ 4. _____
- 5. _____ 6. _____

Signature: _____ Date: _____