Patient Intake Form

Name: ____ Date of Birth: ____________________

Who referred you? ____

What is your diagnosis? ____

Do you have other medical issues that we should be aware of?

- Heart Issues?
- Lung Issues?
- Digestive Problems?
- Pain?
- Depression, Anxiety, etc.?
- Fatigue?
- Other Issues?

____
____

Have you had surgery? Please list the general type and approximately when this occurred.

____
____
____

List all medications that you are presently taking (prescription and over-the-counter). Include the dosages and frequency, if known, and approximately when you started taking them.

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____
____

List all of the supplements that you are presently taking (vitamins, minerals, herbs, etc.). Include the dosages and frequency, if known, and approximately when you started taking them. If needed, use the back of this page.

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____
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Do you have any allergies to medications, foods or chemicals? Please list these:

____

Describe, in general terms, what your diet is like. Include a typical breakfast, lunch, dinner and the types of snacks.

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____
____
____

Do you drink alcohol? ______ If "yes," how much? ___________________________________

Do you smoke? ______ If "yes," how much? _______________________________________

Do you use any recreational drugs? ____

Who do you live with? ____

What type of support circle do you have? ____

Are you married, divorced, single, heterosexual, homosexual? __________________________

Are you presently working? Full time or part time? What is, or was, your occupation?
____

Do you exercise? How much? ____

Do you meditate, pray or engage in any type of spiritual activity? ________________________

Are you involved with psychological counseling now, or have you been in the past? __________

Are you involved with any other therapies such as massage, acupuncture, chiropractic now, or in the past? ____

What do you like to do? What brings joy and satisfaction to your life? ____________________
____
____

Do you have any of the following symptoms:

Fatigue	Urinary Symptoms (pain, bleeding, frequency)
Sleep disturbances	Dizziness
Pain	Memory or concentration problems
Chest pain/tightness/heaviness	Excessive coldness or warmth
Shortness of Breath	Abnormal bruising or bleeding
Nausea	Rashes
Constipation	Depression
Diarrhea	Anxiety or Panic

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Other digestive symptoms Suicidal thoughts

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____

What major life decisions or changes are facing you? ___________________________________

____

What are the most significant stressors in your life right now? ___________________________

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____

What other things would you like us to know? ____

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____

Who would you like us to send a consultation letter to? _________________________________

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