Holistic Health Care
33 Welgelegen Rd, Unit 1A
Cayhill, St.Maarten 00000

Holistic Health Care New Patient Intake Form

Name * _____

Address * _____

Telephone number: * _____

Email Address * _____

May we use your email address occasionally for health related information? * ☐ Yes ☐ No

Are you a current or past patient of Holistic Health Care? _____

If no, who is or was your practitioner? _____

What is your occupation? _____

Marital Status

☐ Single ☐ Married
☐ Common-Law ☐ Separated
☐ Divorced
☐ Others _____

Children * ☐ Yes ☐ No

Name of Emergency Contact * _____

Relationship to Patient * _____

Phone Number for Emergency Contact * _____

Please list other health care providers * _____

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Context of Care Review

Successful health care and preventive medicine are only possible when the physician has a complete understanding if the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your, time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

What are your current healthcare concerns? *

How do you rate your general state of health?

☐ Poor ☐ Fair
☐ Good ☐ Very Good
☐ Excellent

Comments?

Do you have any current diagnosed conditions?

Do you have any past diagnosed conditions?

Do you have any current or past illnesses, accidents or hospitalization?

Do you get regular screening tests? (PAP, blood, ect)

Date of last screening physical exam: _____

_____

_____

_____

Are you currently pregnant? * ☐ Yes ☐ No

Are you currently breastfeeding? ☐ Yes ☐ No

Please list ALL CURRENT prescribed medications, including birth control: * _____

_____

_____

_____

Please list ALL CURRENT supplements/ vitamins: _____

_____

_____

_____

Please list all PAST prescribed medications that you have taken for longer than 3 months: _____

_____

_____

_____

Please list any prescribed medication or supplements that you have had an adverse reaction to in the past and indicate the name, date and reaction: _____

_____

_____

_____

Do you avoid any foods and why? _____

_____

_____

_____

Do you exercise? ☐ Yes ☐ No

How much time do you spend exercising in the course of 1 week: _____

What kinds of exercise do you enjoy? _____

_____

How would you rate your average energy level in a day?(where 1 is lowest and 10 is best) ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

What is the time of day that is your lowest energy? _____

How many hours of sleep do get get each night? _____

Do you wake feeling rested? ☐Yes ☐No

Do you have trouble falling asleep? ☐Yes ☐No

What are your sleep patterns? (include usual times of sleep, wake, naps) _____

With whom do you live? _____

Do you live with pets? ☐Yes ☐No
☐Others _____

What is your height? _____

What is your current weight? _____

What is your ideal weight? _____

Have you lost any weight recently? ☐Yes ☐No

If so, how much? _____

Please list any family medical history (please include parents, siblings, children, grandparents): _____

Alcohol Intake: ☐Do Not Drink Alcohol ☐Occasional Alcohol Consumption
☐Social/Weekend Consumption ☐3-7 days /week
☐Others _____

On average, how many alcoholic drinks do you have per week? _____

Do you currently smoke? ☐ Yes ☐ No
☐ Others _____

If YES - how many cigarettes per day and for how many years? _____

If NO - but used to in the past - how long ago did you quit? _____

Do you use recreational drugs? ☐ Yes ☐ No
☐ Others _____

If YES - explain type and frequency. _____

Do you consume any of the following? ☐ Coffee ☐ Non-herbal Tea
☐ Soft Drinks ☐ Energy Drinks
☐ Others _____

What are 3 goals you want to address at your first visit? _____

What are your long term expectations for working with me? _____

What behaviours/activities do you currently engage in that support your health? _____

What behaviours/activities do you currently engage in _____

that hinder your health? _____

_____

_____

What is your level of commitment to learn and implement changes that will improve your health and well-being? ☐1 ☐2 ☐3 ☐4 ☐5 ☐6 ☐7 ☐8 ☐9 ☐10

If below an 8, what will it take to increase your level of commitment? _____

_____

_____

_____

What potential obstacles do you foresee in addressing factors that are undermining your health, and would make it difficult to follow a treatment plan? _____

_____

_____

_____

Who do you know that will sincerely support you with the beneficial lifestyle changes you will be making? _____

What do you love to do? _____

_____

_____

_____

Do you, or have you ever, had any of the following skin concerns?

☐ Rash ☐ Hives
☐ Acne ☐ Boils
☐ Eczema/Atopic Dermatitis ☐ Psoriasis
☐ Dry skin ☐ Itching
☐ Lumps ☐ Night sweats
☐ Others _____

Do you, or have you ever, had any of the following head concerns?

☐ Tension headaches ☐ Migraine headaches
☐ Head injury ☐ Dizziness
☐ Others _____

Do you, or have you ever, had any of the following eye concerns?

☐ Impaired vision ☐ Use of corrective
☐ Eye pain ☐ Tearing
☐ Dryness ☐ Double vision
☐ Cataracts ☐ Glaucoma
☐ Light Sensitive ☐ Itching

	☐ Redness	☐ Discharge
	☐ Blind Spot	
	☐ Others _____	
Do you, or have you ever, had any of the following ear concerns?	☐ Impaired hearing	☐ Earache
	☐ Dizziness	☐ Discharge
	☐ Infections	☐ Excessive wax
	☐ Others _____	
Do you, or have you ever, had any of the following mouth or throat concerns?	☐ Hoarseness	☐ Gum problems
	☐ Difficulty swallowing	☐ Dental problems
	☐ Sores	☐ Dryness
	☐ Sore throat	☐ Loss of taste
	☐ Bad breath	
	☐ Others _____	
Do you, or have you ever, had any of the following neck concerns?	☐ Lumps	☐ Swollen glands
	☐ Goiter	☐ Pain or stiffness
	☐ Others _____	
Do you, or have you ever, had any of the following respiratory concerns?	☐ Cough	☐ Sputum
	☐ Spitting with blood	☐ Wheezing
	☐ Asthma	☐ Bronchitis
	☐ Pneumonia	☐ Emphysema
	☐ Sleep apnea	☐ Difficulty breathing
	☐ Pain on breathing	☐ Shortness of breath when lying down
	☐ Positive tuberculosis test	
	☐ Others _____	
Do you, or have you ever, had any of the following breast concerns?	☐ Lumps	☐ Pain/tenderness
	☐ Nipple discharge	
	☐ Others _____	
Do you, or have you ever, had any of the following cardiovascular concerns?	☐ Angina	☐ Murmurs
	☐ Chest pain	☐ Swelling in ankles
	☐ Palpitations, fluttering	☐ Elevated cholesterol
	☐ Others _____	
Do you, or have you ever, had any of the following gastrointestinal concerns?	☐ Heartburn	☐ Change in appetite
	☐ Nausea	☐ Vomiting
	☐ Vomiting blood	☐ Belching
	☐ Passing gas	☐ Abdominal pain
	☐ Indigestion	☐ Diarrhea
	☐ Constipation	☐ Blood in stool

☐ Hemorrhoids ☐ Black tarry stool
☐ Jaundice ☐ Liver disease
☐ Gallbladder disease ☐ Food allergy
☐ Hernia
☐ Others _____

Do you, or have you ever, had any of the following endocrine concerns?

☐ Heat intolerance ☐ Cold intolerance
☐ Thyroid condition ☐ Excessive thirst
☐ Excessive hunger ☐ Excessive urination
☐ Excessive sweating ☐ Diabetes
☐ Hypoglycemia ☐ Hormone therapy
☐ Others _____

Are you currently sexually active? ☐ Yes ☐ No

MALE PATIENTS:
Do you, or have you ever, had any of the following reproductive concerns?

☐ Hernia ☐ Testicular problems
☐ Testicular pain ☐ Impotence
☐ Premature ejaculation ☐ Venereal disease (STI, STD)
☐ Discharge
☐ Others _____

MALE PATIENTS: Do you have any of the following routine and diagnostic testing completed within the past 2 years?

☐ Prostate exam/DRE ☐ PSA
☐ Colonscopy ☐ STI
☐ Others _____

MALE PATIENTS: If yes to any of the previous routine testing - what was the date and what were the results?

_____
_____
_____
_____

MALE PATIENTS: Do you have any of the following conditions?

☐ Prostate enlargement ☐ Change in libido
☐ Erectile Dysfunction ☐ Testicular mass/pain
☐ Hernia ☐ Waking at night to urinate
☐ Change in urine stream/flow//urgency/difficulty ☐ STI
☐ Others _____

FEMALE PATIENTS:
Do you, or have you ever, had any of the following reproductive concerns?

☐ Bleeding or spotting between menses ☐ Irregular cycles
☐ Pain during intercourse ☐ Painful menses
☐ Excessive menstrual flow ☐ PMS symptoms
☐ Difficulty conceiving ☐ Low libido/ sex drive
☐ Vaginal discharge ☐ Vaginal itching
☐ Others _____

FEMALE PATIENTS: Do you have any of the following gynecological conditions?

- ☐ Endometriosis
- ☐ Fibroids
- ☐ PCOS
- ☐ Mid-cycle spotting
- ☐ Low libido
- ☐ Infertility
- ☐ STI
- ☐ Others _____

FEMALE PATIENTS: What, if any, PMS symptoms do you experience? _____

FEMALE PATIENTS: When was the date of your last menstrual period? _____

FEMALE PATIENTS: What was your age at first menses? _____

FEMALE PATIENTS: Length of menstrual cycle? _____

FEMALE PATIENTS: Are you menopausal or perimenopausal?

- ☐ Yes
- ☐ No
- ☐ Others _____

If YES, please provide dates of onset and last period. _____

FEMALE PATIENTS: Have you been on Hormone Replacement Therapy?

- ☐ Yes
- ☐ No
- ☐ Others _____

If YES - please list type and duration. _____

FEMALE PATIENTS: Number of pregnancies: _____

FEMALE PATIENTS: Number of live births: _____

FEMALE PATIENTS: Number of abortions: _____

FEMALE PATIENTS: Last gynaecological exam: _____

FEMALE PATIENTS: Last PAP test: _____

Do you, or have you ever, had any of the following urinary concerns?

- ☐ Pain on urination
- ☐ Increased frequency
- ☐ Frequency at night
- ☐ Inability to hold urine

	☐ Frequent infections	☐ Kidney stones
	☐ Blood in urine	☐ Reduced urine flow
	☐ Others _____	
Do you, or have you ever, had any of the following musculoskeletal concerns?	☐ Broken bones	☐ Muscle spasms/cramps
	☐ Weakness	☐ Joint swelling
	☐ Backache	
	☐ Others _____	
Do you, or have you ever, had any of the following peripheral vascular concerns?	☐ Deep leg pain	☐ Cold hands/feet
	☐ Varicose veins	☐ Deep vein thrombosis
	☐ Leg cramps	☐ Extremity numbness
	☐ Extremity swelling	☐ Extremity ulcers
	☐ Others _____	
Do you, or have you ever, had any of the following neurologic concerns?	☐ Fainting	☐ Seizures/convulsions
	☐ Paralysis	☐ Muscle weakness
	☐ Numbness/tingling	☐ Loss of memory
	☐ Involuntary movements	☐ Loss of balance
	☐ Speech problems	
	☐ Others _____	
Do you, or have you ever, had any of the following blood/lymphatic concerns?	☐ Anemia	☐ Easy bleeding/bruising
	☐ Past transfusion	☐ Lymph node swelling
	☐ Others _____	
Do you, or have you ever, had any of the following emotional concerns?	☐ Depression	☐ Anger
	☐ Mood Swings	☐ Anxiety
	☐ Nervousness	☐ Tension
	☐ Phobias	☐ Insomnia
	☐ Sexual difficulties	☐ Drug abuse
	☐ Psychiatric care	☐ Psychological counselling
	☐ Others _____	