The Healing Collective

Initial Appointment Intake

Date _____ Name _____ D.O.B. _____

Address _____

Phone_____* Email_____

*Do we have permission to leave details on this phone's voicemail regarding your treatment? Y / N

Initial_____

Have you been seen in our office before? Y / N

If your circled "N", how did you hear about us? _____

Current Medications

Medication Name	Date Started	Dosage

Current Supplements/Vitamins/Minerals

Supplement Name	Date Started	Dosage

Current Medical Providers:

_____
_____

Allergies? (Food, Medication, Supplements, Environmental)

_____
_____
_____

Hospitalizations and/or surgeries?

_____
_____
_____
_____
_____

Lifestyle/Social

Exercise_____

Diet_____

Beliefs about your current health_____

_____

Drug Use_____ Alcohol _____ Smoking_____

Current or Past Health Conditions (please list)

Autoimmune Conditions _____

Psychiatric _____

Clotting Disorders _____

Eating Disorders _____

Neurological _____

Ears, Eyes, Nose, Throat _____

Cardiac _____

Respiratory _____

Gastrointestinal _____

Urological/Gynecological/Male Health _____

Dermatological _____

Hematological (Blood) _____

Musculoskeletal _____

Infectious Disease _____

Addiction _____

For Women

Last Menstrual Period Date _____

PMS _____

Difficult Menstrual cycle _____

Pregnancies _____

Birth Control_____

Family History (please describe) _____

_____

_____

Chronology of your health experiences (life illnesses, injuries, treatments, onset & resolution, etc.)

In utero _____

Birth _____

Early Childhood _____

Childhood _____

Teens _____

Adulthood _____

*Rate each of the following symptoms based upon your typical health profile for the **past 14 days**.*

Point Scale

0- *Never or almost never* have the symptom
1- *Occasionally* have it, effect is ***not severe***
2- *Occasionally* have it, effect is ***severe***
3- *Frequently* have it, effect is ***not severe***
4- *Frequently* have it, effect is ***severe***

Head

____ Headaches
____ Faintness
____ Dizziness
____ Insomnia

Total _____

Eyes

____ Watery or itchy eyes
____ Swollen, reddened or sticky eyelids
____ Bags or dark circles under eyes
____ Blurred or tunnel vision

Total _____

Ears

____ Itchy ears
____ Earaches, ear infections
____ Drainage from ear
____ Ringing in ears, hearing loss

Total _____

Nose

____ Stuffy nose
____ Sinus problems
____ Hay fever
____ Sneezing attacks
____ Excessive mucus formation

Total _____

Mouth/Throat

____ Chronic coughing
____ Gagging, frequent need to clear throat
____ Sore throat, hoarseness, loss of voice
____ Swollen or discolored tongue, gums, lips
____ Canker sores

Total_____

Skin

____ Acne
____ Hives, rashes, dry skin
____ Excessive sweating

Total_____

Heart

____ Irregular or skipped heartbeat
____ Rapid or pounding heartbeat
____ Chest pain

Total_____

Lungs

____ Chest congestion
____ Asthma, bronchitis
____ Shortness of breath
____ Difficulty breathing

Total_____

Digestive Tract

____ Nausea, vomiting
____ Diarrhea
____ Constipation
____ Bloated feeling
____ Belching, passing gas
____ Heartburn
____ Intestinal/stomach pain

Total_____

Joint/Muscle

___ Pain or aches in joints
____ Arthritis
____ Stiffness/ limitation of movement
____ Pain or aches in muscles
____ Feeling of weakness or tiredness

Total_____

Weight

____ Binge eating/drinking
____ Craving certain foods
____ Excessive weight
____ Compulsive eating
____ Water retention
____ Underweight

Total_____

Energy/Activity

____ Fatigue, sluggishness
____ Apathy, lethargy
____ Hyperactivity
____ Restlessness

Total_____

Mind

____ Poor memory
____ Confusion, poor comprehension
____ Poor concentration
____ Poor physical coordination
____ Difficulty in making decisions
____ Stuttering or stammering
____ Slurred speech
____ Learning disabilities

Total_____

Emotions

____ Mood swings
____ Anxiety, fear, nervousness
____ Anger, irritability, aggressiveness
____ Depression

Total_____

Sex Hormones

____ Hot flashes
____ Low libido
____ Insomnia
____ Poor muscle tone
____ Vaginal irritation/dryness
____ Vaginal bleeding
____ Breast tenderness
____ Breast lump

Total_____

____ Poor Circulation
____ Brain fog
____ Weight gain
____ Weight loss
____ Cold intolerance
____ Hair loss
____ Skin dryness

Total_____

Other

____ Frequent illness
____ Frequent or urgent urination
____ Genital itch or discharge

Total_____

Grand Total_____

Completed by Nurse/Medical Assistant: (for office use only)

Vital Signs:

Height _____ Weight _____ Temperature _____

Blood Pressure _____ Pulse _____

Completed by Provider:

Physical Exam:

Constitutional _____ GI _____

HEENT _____ GU_____

Cardiac _____ Psych/Neuro _____

Pulmonary _____ Breast _____

Assessment and Plan:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Labs_____

_____

_____

Follow-up _____

_____

CPT Code _____ Time Spent w/ pt._____

Signature_____ Date _____