Confidential Patient Information

Patient Contact Information

Name: ____ _________ _____/____/____
(First) (Last) (Sex) (Date of birth)

Permanent Address: __________________________________ City: ______________ State: _______ Zip: ________

Temporary Address: _________________________________ City: ______________ State: ______ Zip: ________

Home Phone: (_____)________________ Cell Phone: (____) ___ _________

Email Address: ____
Preferred method(s) of contact: ❒ Email ❒Text ❒Home phone ❒ Cell phone

Name of nearest relative not living with you: __________________________________ Relation: _______________
Phone: (___)____________________

Additional Patient Information

Today's Date: ____/____/____

Employer: ____ Occupation: ___________________________

Work Address: _______________________________________ City: ______________ State: _______ Zip: ________

Marital Status (circle): Single Married Separated Divorced With Partner Widow

Whom may we contact in case of an emergency: _______________________ Relationship to you: _____________

Emergency Contact #: (_____)___________________

How did you first hear of us?
From another Patient The Internet/website The Newspaper Other

Name of person to thank for referring you to us: ____

Do you have a M.D. primary care or Internist that you also see? ❒ Yes ❒ No

Name ____

Were you referred by another physician: ❒ Yes ❒ No

Referring Physician's Name: ____

Adult Intake Form

Patient Name: ______________________________ **Date of Birth:** ____________

List in order of importance why you are coming in today:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________

Last time you had blood work done and with what physician: ______________________________

List All Surgeries, Hospitalizations, Injuries & Major illnesses, including date occurred:

1) ______________________________
2) ______________________________
3) ______________________________
4) ______________________________
5) ______________________________
6) ______________________________

Past Medical History

Do you have any allergies to any medications or foods? What happens when you have the allergic reaction?

Current Prescription Medications:

	Drug name	Dosage	Taking since	Taking For:
1.				
2.				
3.				
4.				
5.				
6.				

Natural supplements: (vitamins, minerals, herbs, homeopathics etc.)

	Supplement name	Dosage	Taking since	Taking For:
1.				
2.				
3.				
4.				
5.				
6.				

Family History

	Father	Father's Parents		Mother	Mother's Parents		Siblings	Spouse	Children	Other
		GF	GM		GF	GM				
Age (if living):										
Age (if deceased):										
Reason for death:										
Cancer type:										
High Blood Pressure:										
Heart Attack										
Heart Disease:										
Stroke:										
Asthma/Allergies:										
Mental Illness:										
Auto-Immune Disease:										
Diabetes Mellitus:										
Osteoporosis:										

Diet/Lifestyle

List the foods you typically consume for breakfast, lunch, dinner & snacks.

Breakfast	Lunch	Dinner	snacks

How many times each week do you eat desserts (e.g. cookies, cakes, ice cream, candy etc.)?

Do you drink coffee or tea? ❒Y ❒ N If yes, how many cups each day? ______________________________

Do you use artificial sweeteners? ❒Y ❒ N If yes, what type? _________________________

Do you drink soda? ❒Y ❒ N If yes, how many times each week? ____________________________

Do you drink fruit juice? ❒Y ❒ N If yes, how many times each week? ____________________________

How much water do you drink per day: _________________________

If you could eat any food(s) frequently no matter if it was a healthy choice or not, what food(s) would you choose as you favorites or whatever you crave?

Do you have food aversions? (Foods you strongly dislike or always avoid?)

What temperature do you prefer your drinks? **warmed** **room temp** **cool** **chilled** **ice cold**

Do you tend to be: thirsty or not thirsty

Indicate Yes (Y=current), No (N=never) or Past (P=anytime in the past) regarding use of the following:

Alcohol: Y N P **How often & how much:**____________**Any Alcohol Addiction**: Y N P **Any Alcohol Treatment**: Y N P

Smoking: Y N P **Packs per day & number of years**: ____

Recreational Drugs: Y N P **Drugs used:**

Any Drug Addictions: Y N P **Any Drug Treatment**: Y N P

Sleep

How long per night? _________________ **Difficulty falling asleep?**____________ **Difficulty Staying asleep?**__________

Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P

Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P **Perspiration:** Y N P

Circle what you prefer. Do you sleep: Without Covers Partly Covered Fully Covered (Not including Head)

Fully Covered (Including Head) With Arms or Legs Out of the Covers Without Clothing

With a Fan or Air Blowing on You With the Window open

Exercise

How often do you exercise? __________________ **What type of exercise**? ____

For how long each time? ____________________

Weight concern? ❐Y ❐ N

Present Weight: ______________ **Height:** ___________**Weight one year ago**: ______________**Ideal Weight**: ______________

Maximum weight and when: ______________ **Minimum weight as adult & when**: ______________

Good Energy? ❐Y ❐ N

On a scale of 1 to 10 with 1 (lowest) & 10 (highest), what is your average daily energy level?
1 2 3 4 5 6 7 8 9 10

Fatigue? **❐Y ❐ N If yes, when is your fatigue the worst?** Morning Afternoon Evening

If you have fatigue, can you still do what you need to do during the day?

What type of work do you do?____

Do you enjoy your job? ❒**Y** ❒ **N** **Hours worked per week**:____________**Highest Level of Education**:_____________________

Hobbies: ____

Active spiritual practice: ❒**Y** ❒ **N** **Quality of significant relationship**: ______________________________

Sexually Active: ❒**Y** ❒ **N**

Please circle the best approximation of your sexual desire. Please circle the level of your desire and not your actual frequency.

Never 1x/year 1x/3 mo. 1x/mo. 2x/mo. 1x/wk. 2x/wk. 4x/wk. 1x/day 2x/day 4x/day

How often do you actually have sex?

Never 1x/year 1x/3 mo. 1x/mo. 2x/mo. 1x/wk. 2x/wk. 4x/wk. 1x/day 2x/day 4x/day

What types of stressors have you dealt with in the past and present? ______________________________

How do you best deal with those stressors? ______________________________________

History of sexual, mental/emotional, physical abuse: Y N **P** **If so, at what age and by whom**: ____________________

What is your greatest health concern: ______________________________________

How does it limit you the most: ______________________________________

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? ______________________________________

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? If so, describe job.

____

Have you ever had health problems when you put in new carpeting, painted your home, new cabinets or other remodeling? If so, what types of symptoms?

____

Are you particularly sensitive to perfumes, gasoline or other vapors? ❒Y ❒ N

Do you use pesticides, herbicides or other chemicals around your home? ❒Y ❒ N

Do you know of any past or present mold exposure in your home or workplace? ❒Y ❒ N

What type of cookware do you primarily use? How long have you had it?

Do you use plastics? ❒Y ❒ N **Do you microwave food in plastic containers?** ❒Y ❒ N

Do you have a water filter or buy filtered water for drinking & cooking? ❒**Y** ❒ **N**

Review of Systems

Please circle any of the conditions or symptoms below, if you have experienced them significantly within the last 6 months.

GENERAL
Fatigue Weight change Fever / chills Weakness
Night sweats Insomnia Heat/Cold Intolerance
Excessive Hunger/Thirst

SKIN
Itching Rashes Hair/Nail changes Excessive Perspiration

HEAD
Headache Trauma Dizziness

EYES
Vision changes Pain Discharge Blurry Vision Double Vision Eye Disease Eye Injury Dark Circles Under Eyes
Last Eye Exam:________________________________

EARS
Hearing Changes Tinnitus (ringing) Pain Discharge
Itching Infections

NOSE
Bleeding Discharge Sinus infections Allergies
Congestion Decrease in Smell

MOUTH/THROAT
Sores Gums bleeding Hoarseness Loss of Taste
Pain/Difficulty Swallowing Silver Fillings Sore Throat
Last Dental Exam:_______________________________

LUNGS/BREATHING
Wheezing Cough Coughing blood Pain
Shortness of breath

CARDIOVASCULAR
High/Low Blood Pressure Irregular Heart Beats Palpitations
Chest Pain Swollen ankles Calf pain

BLOOD-LYMPHATIC SYSTEM
Anemia Bleeding disorder Excessive Bruising
Swollen lymph nodes

URINARY/URINATION
Pain Waking at night Incontinence Infections
Frequency Urgency Blood In Urine Kidney Stones

GASTROINTESTINAL
Heartburn Indigestion Reflux Excessive Gas Belching
Bloating Appetite Change Nausea Vomiting
Constipation Diarrhea Hemorrhoids Blood in stool
Pain Change in Bowel Movements
Frequency of Bowel Movements:___________________

MUSCLES, JOINTS & BONES
Trauma Pain Arthritis Weakness Leg Cramps

NEUROLOGIC
Fainting Seizures Numbness Tingling Speech problems
Paralysis Tremor Sciatica Carpal Tunnel

MENTAL/EMOTIONAL
Anxiety Depression Fear/Panic Mood Swings Tension
Phobias Memory loss Anger/Irritability Suicidal Ideations

SEXUALLY TRANSMITTED DISEASES
Syphilis Gonorrhea Chlamydia Herpes HPV HIV
Hep B or C Sores / discharge Pelvic pain

BREASTS
Masses Pain/Tenderness Discharge Dry Skin on Breast

FEMALES
Heavy bleeding Pain/Cramping Irregular cycle Spotting
PMS Abnormal PAP Pain w/Intercourse Vaginal Infections
Hot Flashes Vaginal Dryness Change in Libido
Date of last period:_____________
Days between periods: _________
Days periods last__________
Times Pregnant: __________ How Many Births: ___________
Miscarriages: _______________Abortions___________
Last PAP & Pelvic exam date: ___________________
Menopausal? ❒Y ❒ N

Last Mammogram date:_________________________
Last DEXA (bone density) scan:__________Results?________

MALE
Testicular pain Swelling Masses Discharge
Impotency Change in Libido

Homeopathic remedy consideration questions:

Please answer the questions as carefully, thoughtfully, and accurately as possible. Many of the questions may not seem directly related to your main complaint, however, each one may help determine which homeopathic remedy is best suited for you. The information provided is not used in a judgmental way. It is purely to help the practitioner select the most appropriate remedy for you. The more specific, characteristic and/or unusual symptoms are some of the most important. Being as honest & accurate are extremely important.
1 means the least, 5 means the most or 1 means never , 5 means a lot

Which weather conditions are you most troubled by?
1 2 3 4 5 Cloudy 1 2 3 4 5 Clear 1 2 3 4 5 Wet 1 2 3 4 5 Dry

1 2 3 4 5 Storms 1 2 3 4 5 Wind 1 2 3 4 5 Hot Sun 1 2 3 4 5 Change of weather

Which season causes you the most trouble or symptoms typically return?

Are your symptoms ever worse being in the mountains? **At the seashore?**

Are you generally chilly or warm? **Are you generally more sensitive to cold or heat?**

How often do you perspire? (Never) 1 2 3 4 5 (All of the time) **What area of your body sweats the most?** ___________________

What are your feelings toward disease? Optimistic Doubtful of recovery Fearful Anxious

What time(s) of day are you generally worst (mood, energy, symptoms, etc.)

What time(s) are you best?

Are you generally sensitive to and/or troubled by:
1 2 3 4 5 Bright Light 1 2 3 4 5 Darkness 1 2 3 4 5 Open Air 1 2 3 4 5 Drafts

1 2 3 4 5 Stuffy Rooms 1 2 3 4 5 Tight Clothing 1 2 3 4 5 Noise 1 2 3 4 5 Odors

Rate these foods on how much you like or dislike them?
1 2 3 4 5 bacon 1 2 3 4 5 butter alone 1 2 3 4 5 cheese 1 2 3 4 5 chocolate 1 2 3 4 5 coffee

1 2 3 4 5 eggs 1 2 3 4 5 fat (meat, chicken, pork etc) 1 2 3 4 5 fish 1 2 3 4 5 fruit

1 2 3 4 5 ice 1 2 3 4 5 ice cream 1 2 3 4 5 indigestible things (chalk, clay, paper)

1 2 3 4 5 lemonade 1 2 3 4 5 meat 1 2 3 4 5 milk 1 2 3 4 5 pickles 1 2 3 4 5 pasta,breads etc

What type(s) of flavors do you usually like best? Sweet sour salty bitter spicy

Do you experience any specific taste in your mouth (i.e. sweet, bitter, foul, metallic, etc)

Answer as honestly as you can about these personality traits.
1 2 3 4 5 Hurried, impatient 1 2 3 4 5 Slow 1 2 3 4 5 Calm 1 2 3 4 5 Restlessness

1 2 3 4 5 Messy 1 2 3 4 5 Fastidious 1 2 3 4 5 Indolence (Lazy) 1 2 3 4 5 Always busy

1 2 3 4 5 Shy/Timid/Bashful 1 2 3 4 5 Outgoing 1 2 3 4 5 Confident 1 2 3 4 5 fearful

1 2 3 4 5 Anger 1 2 3 4 5 Irritability 1 2 3 4 5 Stubborn 1 2 3 4 5 Impulsive

1 2 3 4 5 Jealousy 1 2 3 4 5 Yielding 1 2 3 4 5 Mildness 1 2 3 4 5 weeps easily

1 2 3 4 5 Aversion of other people/company 1 2 3 4 5 Desire for company 1 2 3 4 5 Talkative

1 2 3 4 5 Critical of self 1 2 3 4 5 Critical of others 1 2 3 4 5 Irresolution (Not being able to decide or stick to a decision)

1 2 3 4 5 Reproaches (find fault, scold, or blame) others 1 2 3 4 5 Reproaches self

1 2 3 4 5 Capriciousness (wants something & when offered you refuse) 1 2 3 4 5 Selfishness

How do you experience sympathy or consolation? (like it) 1 2 3 4 5 (dislike it)

Does it make you feel better or worse when someone consoles you?

How much do you worry about the following?
1 2 3 4 5 Financial Security 1 2 3 4 5 Health 1 2 3 4 5 Mental Functioning 1 2 3 4 5 Morals/past Indiscretions

1 2 3 4 5 Others' (family and close friends) well being 1 2 3 4 5 Religion 1 2 3 4 5 Social Life

1 2 3 4 5 The Future 1 2 3 4 5 Work

How often do you have the following behaviors?
1 2 3 4 5 Abusive 1 2 3 4 5 Breaks Things 1 2 3 4 5 Cursing

1 2 3 4 5 Contrary (Opposite to what is logically expected) 1 2 3 4 5 Insolent (insult, boldly rude)

1 2 3 4 5 Rage 1 2 3 4 5 Rudeness

1 2 3 4 5 Striking others 1 2 3 4 5 Throwing things 1 2 3 4 5 Violence

How often do you make mistakes with the following?
1 2 3 4 5 Numbers 1 2 3 4 5 Words (reading) 1 2 3 4 5 Words (speaking) 1 2 3 4 5 Words (writing)

Are you forgetful of any of the following?
1 2 3 4 5 Dates 1 2 3 4 5 Names 1 2 3 4 5 Numbers

1 2 3 4 5 Of what someone else just said 1 2 3 4 5 Of what you just said 1 2 3 4 5 Of words

How sensitive are you to any of the following?

1 2 3 4 5 Beauty 1 2 3 4 5 Criticism 1 2 3 4 5 Cruel Stories

1 2 3 4 5 Frightening things 1 2 3 4 5 Being made fun of 1 2 3 4 5 Music

1 2 3 4 5 Reprimand 1 2 3 4 5 Rudeness 1 2 3 4 5 The suffering of others

How afraid are you of the following?
1 2 3 4 5 Animals 1 2 3 4 5 Being alone 1 2 3 4 5 Death

1 2 3 4 5 Relative's Death 1 2 3 4 5 Impending Disease 1 2 3 4 5 Downward Motion

1 2 3 4 5 Evil 1 2 3 4 5 Failure 1 2 3 4 5 Falling

1 2 3 4 5 Ghosts 1 2 3 4 5 Heights 1 2 3 4 5 Misfortune (bad luck)

1 2 3 4 5 Of a Crowd 1 2 3 4 5 People 1 2 3 4 5 Robbers/Intruders

1 2 3 4 5 Snakes 1 2 3 4 5 Spiders 1 2 3 4 5 Strangers

1 2 3 4 5 That something will happen 1 2 3 4 5 Darkness 1 2 3 4 5 Thunderstorms

1 2 3 4 5 Water 1 2 3 4 5 Wind

Which best describes your feelings toward any Significant past emotionally traumatic events:
Resolved Grief Dwells on Past Inconsolable Remorse Guilt

Feeling towards people close to you:
Loving Affectionate Indifferent Resentment Hatred

Feeling toward life:
Love life Indifferent Bored Weary of life Loathing of life Desires death Suicidal thoughts Suicidal disposition

Feeling toward spouse/lover:
Loving Affectionate Dissatisfaction Disappointed Indifferent Resentment Hatred