

INTAKE FORM

Date: _____

Married? _____ Divorced? _____ Single? _____ Children/dependents/#of? _____

Blood type O | A | B | AB

Name _____ Telephone () _____

Address _____ City/State _____

Email Address _____

Sex _____ DOB ____/____/____ Age _____ Employment _____

Hobbies and Special Interests _____

Physical Activities _____

How did you hear about us? _____

List medications, including herbs, supplements, vitamins, and therapies:

Medical doctors or other practitioners _____

Prescription drugs: _____

Over the counter drugs: _____

Herbs, Supplements, Vitamins, Therapies _____

Medical History (please list all major past illnesses)

Major Illnesses: _____

Injuries: _____

Operations: _____

Have you moved in the past year? _____ Has someone close to you passed away in the past year? _____

Medical History of Relatives (Briefly):

Grandparents _____

Parents _____
Aunts/Uncles _____
Siblings _____
Children _____

A. Primary Complaint (Describe to the best of your ability): _____

When did you first notice the Primary problem? _____

B. Other Health Issues:
(List all other symptoms whether they seem related to your primary complaint)

For Women:

What is the length of your menstrual cycle? _____ Excessive or Light flow _____ Clotting? _____
Cramping: Y/N Before _____ After _____ Duration _____
PMS: Duration/Severity? _____
Other changes during menstrual cycle? _____ Digestion? _____

Health and Self-Awareness Inquiries

Briefly describe how you feel about your life _____

What are your strengths? _____

Any special ambitions or desires? _____

What are the Strongest/predominant emotions in your life? _____

Sad/Grief/Depression/Moodiness/Irritable/Worrisome/Angry/Nervous/Frustrated/Anxiety/Panic/Cry/Fear/Shame
How would you describe your energy levels? _____

Your sex drive? _____ Were you Breast-Fed? _____ How long? _____

What season is your favorite? _____ Are you Sensitive to temperature changes? _____

Any phobias? _____

Describe your digestion? _____

Bowel movements/day? _____ What time of day most frequent? _____

Describe (consistency, color, texture) _____

Do they float or sink? _____ Any gas, bloating, or flatulence? _____

How soon after meals? _____ Smelly? _____

Urine Frequency _____ Color/Odor? _____

How well do you sleep? _____ How long per night? _____

Do you fall asleep easily? _____ Do you wake easily? _____

How do you feel upon waking? _____

Do you use any of the following (specify Type, frequency and quantity)

Remember: There are NO judgements here. This is about restoring health & balance, not placing blame

Alcohol: _____ Tobacco: _____ Coffee: _____ Soft drinks: _____ Marijuana: _____

Cocaine: _____ Methamphetamines: _____ Heroin: _____ Other recreational drugs: _____

SYMPTOM SPECIFICS (please circle what applies to you)

Headaches: Basal/Temples/Cluster/Crown/TMJ/Frontal/Migraine(prodromal-halluc./photophobia/olfaction/nausea)Ears:

Noise(Ring/Hiss/Pound)/Plug/Pop/Ache/Drain/Itch/Loss/Dizzy/Wax Tongue: Thick/Coated/SWOLLEN/RED/PAINFUL

Eyes: Burn/Tear/Ache/Red/Dry/Film/Itch/Blur/Floaters/Spots/Tired/Puffy/Stye/Twitch/Circles

Sinus: Dry/Drain/Plug/Post(white/yellow/green/gray/brown/blood/clear)/Sneezing/Smell loss/Taste loss/Thirst

Sore Throat/Hoarseness/Cough(dry/productive)/Allergie/Fever/Chills/BAD BREATH/Cankers/Blisters/Flu

Neck Stiffness/Shoulder Tension/LIPS CRACKED/Dry mouth/Cold,sweaty hands,feet/gums/teeth/glands/SWALLOW TROUBLE

Chest:Tension/Tight/Pressure/Heavy/Anxiety/Congestion/Pain/Sternal

Sharp Heart Pain/Palpitations/FAST HEART/IRREGULAR/Murmur/Arm pain

Shortness of Breath: Constant/Exertion/Asthma/Wheeze/Air hunger/Yawning/sighing/

Heartburn/Indigestion(aches/cramps/nausea/queasy)/Bloat/Gas/Belch/Ulcer/H.H.

Bowels: Regular/Incomplete/Sluggish(every ___ days)/Cramps/Laxative/Suppositories/Enemas/Colonics/Bulk

Fecal Consistency: Soft/Ribbons/Mucous/Normal/Hard/Pebbles/Dry/Pain/Diarrhea/Constipation/difficult/fast/slow

Rectum: hemorrhoids: History/Current (swollen/burn/blood/distend/itch/sting/ache/cramp)_____

Prostate: History/Current (burn/ache/pain/restrict/dribble/emission/swell)

Vagina (burn/itch/dry/pain/blood) Discharge (clear/white/yellow/green/brown/odor)

Menses: Regular/Irregular (early/late)/Skip BIRTH CONTROL pill LMP

Flow (heavy/moderate/light/long/brief) Cramps-mild/med/severe/back

Low Abdominal Puffiness/Fluid-face/hands/feet/body

Breast Tenderness/Acne(pre/mid/post)/Spotting/Clots

PMS -(Mood swing/irritable/depression)/Breast/Fluid/Tired

Ovulation: Pains/Cysts/Discharge/Regular/Irregular/Fibroids

Breast Feeding/Fibrosis/Lump/Discharge/Prosthesis/Reduction/Tender

Vegetables – Cooked _____

Vegetables – Raw, including salads _____

Nightshade (potato, tomato, eggplant, peppers hot/sweet) _____

Oxalic veggies: (spinach, chard, beets) _____

Temperate Fruits: (apple, berries, tree fruits, pears, etc...) _____

Tropical Fruits: (banana, citrus, papaya, pineapple, guava, etc...) _____

Fruit juices _____

Other: _____