INTAKE ASSESSMENT

This is an *extensive* intake form with many questions to answer. Some of these questions may or may not pertain to your health and what you may be experiencing. These questions help to put together a picture of your current health and your answers may help in finding undiagnosed conditions as well as connections between ailments.

Please mark any questions you would prefer to discuss in person.

Please relax and take your time while completing this questionnaire; provide information you are comfortable sharing.

Today's Date: ____ Preferred Pronoun(s): ________________________________

Name: ____

Sex: born as ___ M ____ F Identify as: ____________________ Birthdate: _____/_____/_____ Age: _________

Mailing Address: ____

Email Address: ____

Phone: (H) ____ (C) ____

How may we contact you? Check all that apply: ___phone ____voicemail message _____ text message ____ email

Would you like to receive emails regarding upcoming events and promotions? ____ Yes _____ No

Emergency Contact Name: ____

Relationship: ____ Phone: ____________________________________

Address: ____

Your Occupation: ____

Do you feel safe in your current living situation: ____

Do you have a primary care physician? ______ No ____ Yes (complete information below)

Physician Name: ____

Physician Office Phone Number: ____

Are you receiving care from other healthcare providers regarding your health for any reason? If yes, please list the provider's name and reason for receiving care:

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Have you experienced any of the following in the past or experiencing any now? Check all that apply:

____ Blood Thinning	____ Diabetes	____ Hepatitis	____High Blood Pressure	____Migraines
____ Heart Disease	____ Seizures	____ Rheumatic Fever	____ Venereal Disease (STD)	____ Stroke
____ HIV / AIDS	____ Bleeding	____ Thyroid Disease	____ Birth Trauma	____ Cancer
____ Pacemaker	____ Vein Condition	____ Low Immunity	____ Mononucleosis	____ Asthma
____ Bleeding Tendency	____ Nervous Disorder	____ Implanted Joints	____ Bone Stabilizer or Replacement	____ Surgical

Please list all past surgeries, major illnesses, injuries and hospitalizations with the date or your age as best you can remember them:

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Have you used antibiotics heavily in the past? Please list name / type, reason for use, and the date or your age at the time:

____
____
____

Please list medications, prescriptions, and supplements you are currently taking:

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____
____
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____
____

Please list anything you would like to share about your family health history that may be relevant to your own health: (especially significant may be diabetes, cancer, stroke, heart conditions, seizures, etc.)

____
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Do you smoke? ____ No _____ Yes If yes, what? ______________________________
How much? ______________________ How often? ______________________
When did you begin smoking? ______________________________________
Do you drink alcohol? ____ No ____ Yes If yes, what?_________________________
How much? ______________________ How often? ______________________
When did you begin drinking alcohol? ______________________________
Do you partake of any other drugs? ____ No ____ Yes If yes, what? _______________
How much? ______________________ How often? ______________________
When did you begin taking this / these drugs? ________________________

Check all the following that pertain to you:

Heart Energy:

___ Palpitations	____ Restlessness	____ Frequent dreams	___ Sores on tongue
___ Anxiety	____ Chest pain	____ Wake unrefreshed	___ Mental confusion

Spleen Energy:

___ Low appetite	____ Pensive	____ Fatigue after eating	___ Gurgling noise in stomach
___ Bruise easily	____ Gas	____ Over-thinking	___ Abdominal bloating
___ Hemorrhoids	____ Worry	____ Crave sweets	___ Crave carbohydrates

___ Prolapsed organs: which one(s): ____
___ Abrupt weight loss or gain: which one(s): ___________________________________

Stomach Energy:

___ Mouth sores	____ Stomach pain	____ Burning sensation after eating
___ Vomiting	____ Belching	____ Acid regurgitation
___ Bad breath	____ Heartburn	____ Bleeding, swollen or painful gums
___ Hiccups	____ Ulcer	____ Large appetite

Dampness:

___ Puffiness in face	____ Nausea	____ Mental fogginess	___ Heavy sensation in body
___ Chest congestion	____ Snoring	____ Mental sluggishness	___ Swollen hands and/or feet

Lung Energy:

___ Sadness	____ Dry mouth	____ Nasal discharge	___ Alternating chills and fever
___ Melancholy	____ Dry throat	____ Nose bleeds	___ Sinus congestion
___ Cough	____ Dry nose	____ Sneezing	___ Sore throat

___ Allergies: to what? ____

Liver / Gallbladder Energy:

___ Depression	____ Muscle spasms	____ Recreational drugs	___ High-pitched ringing in ears
___ Convulsions	____ Skin rashes	____ Tingling sensation	___ Gallstones (history or current)
___ Numbness	____ Anger easily	____ Neck/Shoulder tension	___ Temple/Eye headaches
___ Seizures	____ Lump in throat	____ Bitter taste in mouth	___ Frustration and/or irritability
___ Alternating diarrhea and constipation		____ Muscle twitching or cramps	
___ Trouble adapting to change		____ Drinking alcohol	

Kidney / Bladder Energy:

___ Sore knees	____ Kidney stones	____ Memory problems	____ Osteoporosis / Osteopenia
___ Weak knees	____ Easily startled	____ Excessive hair loss	____ Low-pitched ringing in ears
___ Fear	____ Low back pain	____ Easily broken bones	____ Tooth problems

Other Energy Issues:

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____

Do you exercise regularly? ____ No ____ Yes If yes, describe what you do and how often:

____
____

Your current emotional stress scale: (please circle)

1 2 3 4 5 6 7 8 9 10

Low Stress Moderate Stress Extremely Stressed

What do you typically do: to relieve stress / to relax / take time for yourself?

____
____
____
____
____
____

How many hours do you usually sleep per night? __________________ When do you go to bed? ___________________
Do you wake feeling refreshed? ____

Current Height: ___________________ Current Weight: ______________ Weight one year ago: __________________
What is the most you have ever weighed? ___________________________ When? ______________________________
How often do you have a bowel movement? ____

Do you drink coffee? _____________________________ If yes, how much? ______________________________________
Do you drink caffeinated tea? _____________________ If yes, how much? ______________________________________
Do you drink soda? Regular Diet None If yes, how much? ______________________________________
Do you have regular eating habits? ____
Do you eat while engaged in other activities / occupations? ____
Do you eat more when feeling stressed or depressed? ____
Do you experience sudden drops in energy? ____ No ____ Yes If yes, when? __________________________________

Anatomically Male: Check all that apply

___ Swollen testes ____ Testicular pain ____ Trouble with urination (frequency, hesitation, pain, dribbling)
___ Impotence ____ Premature ejaculation ____ Coldness / Numbness in external genitalia

Are you currently sexually active: ___ No ____ Yes

Sexually Transmitted Disease(s): If yes, which one(s), and past or present:
____

Other issue(s):
____
____

Anatomically Female:

Menstruation:

Age of first menstruation: ____
Date of last period: ____
Periods generally last ___________________ (number of days) and occur every _________________ (number of days)
Bleeding during periods tends to be: ___ Light ____ Moderate ___ Heavy ___ Extremely Heavy

Do you experience any of the following regarding your period? If yes, indicate when.

Nausea	______ Before	______ During	______ After
Vomiting	______ Before	______ During	______ After
Light-Headedness	______ Before	______ During	______ After
Headaches	______ Before	______ During	______ After
Migraines	______ Before	______ During	______ After
Anxiety	______ Before	______ During	______ After
Depression	______ Before	______ During	______ After
Irritability	______ Before	______ During	______ After
Weepiness	______ Before	______ During	______ After
Breast Tenderness	______ Before	______ During	______ After
Water Retention	______ Before	______ During	______ After
Pain	______ Before	______ During	______ After

What type? (dull, sharp) ____
Lasting how long? ____

Food Cravings ______ Before ______ During ______ After

For what? ____

Lasting how long? ____

Sexual Health:

Are you currently sexually active: ___ No ____ Yes   Pain during intercourse: ____ No ____ Yes

Sexually Transmitted Disease(s): If yes, which one(s), and past or present:

____

Pregnancy:

Are you now or could you be pregnant? ____ No ____ Yes   Currently trying to conceive? ____ No ____ Yes

Past pregnancies:

Number of Pregnancy	Your age at time of pregnancy	Resulting in live birth	Vaginal or Cesarean Section

Menopause:

Age at hysterectomy: ____ Full _____ Partial _______

Age at menopause: ____

If currently perimenopausal or menopausal, are you taking Hormone Replacement Therapy? ____ No ____ Yes

List symptoms and concerns:

____

____

____

Current Concerns:

Please indicate the healthcare concerns you would like to address today and how long they have been of concern:

(choose two or three of the most pressing)

____

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____

Have you received a diagnosis for these concerns from your primary care physician? ____ No ____ Yes
If yes, please explain:

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What other treatments have you previously received to address these concerns?

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How do these concerns impact your life? Do they prevent you from doing the things you need and want to do?

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____
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____

What are your goals regarding these concerns?

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____
____

How willing are you to make changes to meet these goals?

_______ Very willing; I will do whatever it takes
_______ Willing; I have tried so many things already
_______ Somewhat willing; I don't know what I can do
_______ I don't think there is anything I can do
_______ OTHER: ____

What role do you see your healthcare providers playing in helping you reach your goals?

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____
____
____

Are you interested in having me collaborate with your other healthcare providers to integrate your care?

____ No _____ Yes If yes, please list:

Provider (1) Name: ____

Provider Phone: ____

Provider (2) Name: ____

Provider Phone: ____

Provider (3) Name: ____

Provider Phone: ____

Provider (4) Name: ____

Provider Phone: ____

Printed Patient Name: ____

Patient Signature: ____

Date of Signature: ____