New Patient Intake Form

Name ______________________________________ Date ____________________
Age________________ Date of Birth_______Location___________ Sex F M
Address ____
City ___________________ State _____________ Zip Code ________________
Telephone (home) ______________________(work)_________________________
E-mail ____
Occupation_____________________ Hours per wk______ Retired ____________
Employer______________________ Education ____________________________

Are you: Married___ Separated___ Divorced____ Widowed____ Single____
Significant Partnership_____
Live With: Spouse___ Partner___ Relatives___ Friends___ Alone___ Parents___

Next of Kin or other to reach in an emergency______________________________
Relationship___________ Address _______________________________________
Phone_______________________________________

When and where did you last receive medical or health care?_______________________
____
What was the reason?____

List your most important health concerns (Symptoms, system, or diagnosis) List as many as you can think, in order of importance, and when it began.
1.)____
2.)____
3.)____
4.)____
5.)____
6.)

Briefly explain your expectation and/or desired outcome for seeing the doctor:

Family History

(Check those applicable)	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health G:good F:fair P:poor						
Cancer						
Diabetes						
Heart Disease						
High Blood Pressure						
Stroke						
Epilepsy						
Mental Illness						
Asthma, Hayfever, Hives						
Anemia						
Kidney Disease						
Glaucoma						
Tuberculosis						
Age (at death)						
Cause of death						
Other:						

(For the following sections, please circle Y=yes or N=no)

Childhood Illness/Immune titers

Scarlet Fever Y N | Diphtheria Y N | Rheumatic Fever Y N

Mumps Y N | Measles Y N | German Measles Y N

Other________________________________

Acute illness(circle): STREP - MONO - TONSILITIS - EAR INFECTIONS

Positive markers(Borrelia, Babesia EBV CMV EBV)

Parasites/OTHER:________________________________

Reoccurring acutes:____________________ Cold/flu: More than twice a year Y N

Antibiotic use(circle): None - occasional - frequent - all the time – In the past:

Hospitalization and Surgery(nondental)

Type	Date	Notes/complication

Traumas and Scars

Type / Location	Date	Notes/ Complications

Dental History

Braces? Y N
Head Gear? Y N
Root Canals Y N How Many? Current? Location?
Infections? Carries? Y N If yes please explain:
Dental Surgeries or Implants? Y N
If Yes please describe:

Do you have your wisdom teeth? If removed, when:
Do you wear any guards or mouthpieces? Y N
Are you aware if you excessively grind your teeth at night? Y N
Dental Amalgams / Implants
How many silver / mercury fillings do you currently have? ______
Have you had silver / mercury fillings removed? no yes ⇒ Number removed __
When? ____
How many gold fillings / caps do you currently have ? ______
Do you have implants of silicone, teflon, etc. anywhere in the body no yes If so, where, and for how long? ____

Who is your dentist?________________________________

X-Rays/ Scans/ and Special Studies

Type	Results	Contrast (Type)Y N	Date

Electrocardiogram Y N Electroencephalogram Y N

Immunizations(vaccines)

Polio Y N Pertussis Y N
Tetanus shot (not antitoxin) Y N Diphtheria Y N
Measles/Mumps/Rubella Y N Other _______________________
Any negative reactions Y N explain:_____________________________________

Allergies (Food, Drug, Environment, other)

Allergen	Reaction	Last exposure (date)

Current Medications and supplements

Do you take or use?

Laxatives	Y N	Pain Relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite Suppressants	Y N	Sleeping Pills	Y N
Tranquilizers	Y N	Thyroid Medication	Y N		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, include dose and frequency if able

Environmental Illness and Detoxification

Hobbies____

List all *General* locations in which you have lived: ______________________________

____

How many hours a day do your talk on a cell phone or wireless phone?

Do you wear headphones? Wireless or wired?

Blue tooth or air tube?

Do you practice EMF (electromagnetic field) hygiene at work or in the house?

Ex:Turning machines + screens off, grounding sheets, airplane mode, smart-meter cover, EMF measuring devices, et.

None Some A lot

Exposure History

Heavy traffic(excessive)

Vehicle idling area	no	yes (please specify)	Live/*lived* nearby or commute:
Dump site	no	yes (please specify)	____________
Farm(s)	no	yes (please specify)	____________
Industrial plants	no	yes (please specify)	____________
Radiation source	no	yes (please specify)	____________
Polluted lake/stream	no	yes (please specify)	____________

OTHER? ____________

Home & Hobby

How long have you lived in your present residence?________ How old is it?__________
If more than 40 yrs old, do you have Asbestos insulation or vinyl tile Flaking paint
What type of dwelling is your residence? House Mobile home
Apartment ⇒ O basement O above store O highrise⇒floor___
Does your residence have an attached or underground garage: no yes
What type of fuel is used for heating your home: Gas Oil Wood Electric Propane
Have you ruled out Radon Gas in your home? Y N
Do you have carbon monoxide detectors? no yes
Have you done any painting / renovating / bought new large furniture? no yes
⇒ If so, When? _____________ What? _____________

Who smokes in your home? _________________________ Car? ___________________
Do or did you use pesticides or herbicides (bug or weed killers, flea / tick sprays, collars, powders, etc.) in you home or on your pets? no yes (specify) ________________
____
⇒ On your lawn or garden? no yes (specify) ______________________

What is your water source for bathing? City Well Other__________________

What do you do for exercise and how often?

Skin Brush Y N Enemas or Colonics Y N Past How often? Did they help?
Do you sweat while exercising or use saunas? Y N
How much on average do you sleep? Circle: <6 6-8 >8
Do you wake up easily and feel rested? Y N elaborate:
Do you fall asleep easily and stay asleep? Y N and Y N
How could your sleep be improved?

Occupation

1. Please list the significant chemicals, solvents, heavy metals, paints, dusts, fibers, fumes, radiation, biologic agents (bacteria, molds, viruses) and phusical agents (extreme heat, cold, vibration, noise) that you have been exposed to;

Past/Present Jobs and Hobbies	For how long did you do this?	Exposures	Protective measures and equipment
1)			
2)			
3)			
4)			
5)			
6)			
7)			
8)			

Please list any protective measures taken (e.g. showering at work, laundering clothes at work, etc.) or protective equipment used (e.g. gloves, apron, mask, respirator, hearing protectors, etc.)

2. The following questions are about your present or most recent work environment:
   Age of building: _____ Number of floors: ___ Approximate # of occupants: ____
   Neighborhood: Rural Commercial Industrial

Which of the following does / did your present or most recent work environment have?

Indicate any significant or suspicious **past** exposures:

laboratory
cafeteria
windows that open
banks of computers
manufacturing area
central air conditioning
unvented smoking areas
partitions or room dividers
unvented copy machines
nearby parking garage
carpets – *How old?*

3. Note occurrences in your work environment over the past 12 months
   use pesticides: indoors outdoors, fire, smoke flood, water leaks carpet cleaning
   new flooring, furniture,etc.*(specify):* _________________ construction renovation
   painting chemical spill, leak*(specify):* _____________________ accidents stress

Note any exposures from the past not included above:_____________________________

Home and Person

1. Appliances and Environment — Notes:

Damp, musty basement or crawl space	no	yes
Wet windows or outside closet wall	no	yes
Water leaks	no	yes
Visible mold	no	yes ⇒ where?
Stagnant stuffy air	no	yes
Gas or propane stove	no	yes
Other gas appliances	no	yes (*specify)*
Wood stove or fireplace	no	yes
Air Conditioning	no	yes
Electrostatic air cleaner/filters	no	yes
Other air cleaner(s)/filter	no	yes
Carpets: How old?	no	yes ⇒ *Where?*
Photocopier / fax machine / printer	no	yes ⇒ type?

2. Synthetic Chemicals

How often do you use scented personal products (please check box)

Scented Product:	Soap	Lotion	Cosmetics	Hair permanent / Hair tint	Perfume/ Aftershave	Others?
Never						_______
Occasionally						_______
Daily						_______

Symptoms linked with exposure to synthetic chemical(paints, perfumes, cosmetics, engine exhaust, tar, new cars interiors, etc.?) no yes please specify:

Person-Made Chemical	Symptoms Linked with Low-level Exposure	Presently Affected? 1 = a little 2 = somewhat 3 = a lot	In the Past 1 = a little 2 = somewhat 3 = a lot

3. Smoking history

Are you currently a smoker (daily or almost every day)? no yes
If YES, average number of cigarettes per day: _____ Number of years: _____
If NO, have you ever smoked tobacco (daily or almost daily)? no yes

- If YES, number of years you smoked: ____ Average # cigarettes per day: ____
- When did you last smoked regularly? ____________

Have you ever regularly used other tobacco products? no yes

- If YES, what / how much / and when?

  ____

Dietary Questionnaire

1. Who grocery shops for you? ____
   Where? chain grocery store health food store market other ________
2. Who cooks for you? __________________________
3. Please indicate foods and beverages most typically consumed for each of the following meals and the times at which they are most typically eaten.

Foods / Snacks	Please specify typical meals or foods	Time	Beverages	Please Specify	Time
Breakfast			Breakfast		
Mid-morning			Mid-morning		
Lunch			Lunch		
Mid-afternoon			Mid-afternoon		
Dinner			Dinner		
Evening			Evening		

4. Consumption of beverages linked to symptoms?

- Water ⇒ # 8 oz glasses per 24 hours: tap water filtered distilled bottled (glass) bottled (plastic) symptoms:
- Beer, ale ⇒ #12 oz containers/week: symptoms:
- Wine ⇒ # of 6 oz glasses per week: symptoms:
- Alcohol(whisky,etc)⇒# of 1oz drink/week: ___symptoms: ______
- Coffee ⇒ # 8oz cup/espresso shot/24 hours: symptoms:
- Tea ⇒ # of 8 oz cups/24 hours: symptoms:
- Soda ⇒ # 12 oz/ 24 hours: Reg or Diet symptoms:
- Other(s) ______________________ Any symptoms: ___________________

5. Do you eat fish? no yes ⇒ On average servings (3-4 oz) per week? ___
   What are the types of fish that you eat, in order of frequency:

____

6. Please list foods / beverages that do not agree with you (e.g. stuffy nose, heartburn, bloating, diarrhea, sleepiness, difficulty concentrating, etc.) or cause allergic reactions

List foods / beverages that are a problem	What problem(s) do they give you?	Approximately how often do you eat / drink these problem foods?			
		Never	Occasionally	Daily	More than daily

(e.g. hives, rashes, shortness of breath, wheezing, anaphylaxis, etc.):

7. Please list any foods / beverages that you crave or that help you to feel better

List foods that you crave or that help you to feel better	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More than once daily

What are your dietary staples? ____________________________

What foods , if any, do you wish you could consume more often?

What foods, if any, should you be consuming more often?

Are you able and willing to modify your diet or food choices for any amount of time?

Review of Symptoms

(**Y** = a condition you have now. **N** = never had. **P** = condition you have had in the past)

General

Item	
Weight	____________
Weight 1 yr. ago	____________
Maximum Weight	____________
When	____________
Height	____________
Fatigue	Y P N

Skin

Item	
Rashes	Y P N
Other skin conditions	Y P N
Itching	Y P N
Color Change	Y P N
Lumps	Y P N
Night Sweats	Y P N

Head

Item	
Headaches	Y P N
Head Injury	Y P N

Eyes

Item	
Impaired Vision	Y P N
Glasses or Contacts	Y P N
Eye Pain	Y P N
Tearing	Y P N
Dryness	Y P N
Double Vision	Y P N
Glaucoma	Y P N
Cataracts	Y P N

Ears

Item	
Impaired hearing	Y P N
Ringing	Y P N
Earaches	Y P N
Dizziness	Y P N

Nose and Mouth

Item	
Frequent Colds	Y P N
Sore Tongue	Y P N
Gum Problems	Y P N
Hoarseness	Y P N
Teeth Problems	Y P N
Sinus Problems	Y P N

Neck

Item	
Lumps	Y P N
Swollen Glands	Y P N
Goiter	Y P N
Pain or Stiffness	Y P N

Respiratory

Item	
Cough	Y P N
Sputum	Y P N
Spitting up Blood	Y P N
Wheezing	Y P N
Asthma	Y P N
Bronchitis	Y P N
Pneumonia	Y P N
Pleurisy	Y P N
Emphysema	Y P N
Difficulty Breathing	Y P N
Pain when Breathing	Y P N
Shortness of Breath	Y P N
At night	Y P N
Lying down	Y P N
Tuberculosis	Y P N

Cardiovascular

Item	
Heart Disease	Y P N
Angina	Y P N
High Blood Pressure	Y P N
Murmurs	Y P N
Rheumatic Fever	Y P N
Chest Pain	Y P N
Swelling in ankles	Y P N
Palpitations, Fluttering	Y P N

Gastrointestinal

Item	
Trouble Swallowing	Y P N
Heartburn	Y P N
Change in Thirst	Y P N
Change in Appetite	Y P N
Nausea	Y P N
Vomiting	Y P N
Vomiting Blood	Y P N
Bowel Movements	
How Often	__________
Is this a change	____________
Blood in Stool	Y P N
Belching or passing gas	Y P N
Jaundice (yellow skin)	Y P N
Liver Disease	Y P N
Gall Bladder Disease	Y P N
Ulcer	Y P N
Hemorrhoids	Y P N

Urinary
Pain on Urination Y P N
Increased Frequency Y P N
Frequency at Night Y P N
Inability to hold urine Y P N
Frequent Infections Y P N
Kidney Stones Y P N
Female Reproduction
Age Menses Began ____________
Average Number of days _____
Length of Cycle ____________
Bleeding Between Periods Y P N
Are Cycles Regular Y P N
Pain during intercourse Y P N
Painful Menses Y P N
Vaginal problems Y P N
Excessive Flow Y P N
Birth Control Y P N
What Type? _______________
Number of Pregnancies ____________
Number of Live Births _____________
Number of Miscarriages ____________
Number of Abortions _______________
Difficulty Conceiving Y P N
Menopausal Symptoms Y P N
Are you Sexually Active Y P N
Sexual Difficulties Y P N
Venereal Disease Y P N
Breasts
Do You Self Exam Y P N
Lumps Y P N
Pain (or tenderness) Y P N
Nipple discharge Y P N
Male Reproductive
Hernias Y P N
Testicular Masses Y P N
Testicular Pain Y P N
Penis problems Y P N
Are you sexually Active Y P N
Sexual Difficulties Y P N
Prostate Disease Y P N
Venereal Disease Y P N
Discharge or Sores Y P N
Musculoskeletal
Joint Pain or Stiffness Y P N
Arthritis Y P N
Broken Bones Y P N
Muscle Spasms Y P N
Weakness Y P N
Peripheral Vascular
Deep Leg Pain Y P N
Cold Hands and Feet Y P N
Varicose Veins Y P N
Thrombophlebitis Y P N
Neurologic
Fainting Y P N
Seizures Y P N
Paralysis Y P N
Muscle Weakness Y P N
Numbness or Tingling Y P N
Loss of Memory Y P N
Emotional
Depression Y P N
Mood Swings Y P N
Anxiety Y P N
Tension Y P N
Endocrine
Hypothyroid Y P N
Heat or Cold Intolerance Y P N
Excessive Thirst Y P N
Excessive Hunger Y P N
Blood
Anemia Y P N
Easy Bleeding or Bruising Y P N

Please tell me anything else relevant to your physical, mental, or emotional well-being?