Clinic Intake Form

All Answers are Confidential—Please Answer as Completely as Possible

Name_____ Height_____Weight____ Blood Pressure_____

Occupation_____ Occupational Risks/Stresses_____

Chief Complaint_____

History of Chief Complaint_____

_____

Past Medical History_____

_____

Family/Genetic History (Underline if you have a history of the following; circle if a family member has experienced)

Addictive Disease Allergies Arthritis Auto-Immune Disease
Cancer Cardiovascular Disease Depression Diabetes
Endocrine Disease Genetic Structural Abnormalities Glandular Disease
Headaches Hepatitis Type____ HIV/AIDS Hyperglycemia
Hypertension Hypoglycemia Immunity Disorders Impotence Kidney Disease
Liver Disease Neurological Disorders or Disease Respiratory Disorders or Disease
*Urogenital Disorders or Disease Other*_____

Medications and Supplements taken_____

_____

Lifestyle (Any stresses, smoking, alcohol consumption, work hours, etc.)

_____

_____

Any issues related to:

*Eyes*_____

*Ears*_____

*Nose*_____

*Throat*_____

*Skin*_____

Body Temperature (Please underline if you experience)

Cold Hands and Feet Hot Hands and Feet Hot Torso Cold Torso

*Head Feels Hot Head Feels Cold Other*_____

Any abnormalities with perspiration?_____

Briefly discuss your appetite and thirst (strength, cravings)_____

_____

List by number taste preferences *Sweet___ Sour___ Salty___ Bitter___ Spicy___*

What does your diet mainly consist of?_(Please list an average day's meals)

_____

_____

_____

_____

Do you have problems with digestion?_____

Frequency and consistency of bowel movements_____

Frequency and color of urination_____

For Men, Date and Results of Last Prostate Exam_____

For Women, Date and Results of Last Pap Smear_____

How long and how sound is your sleep?_____

_____

How is your energy level? Are there times when it is better or worse during the day?

_____

What kind of exercise do you do, and how often?_____

_____

What are your predominant emotions after a hard day?_____

Do you experience pain?_____

*Where*_____

*When*_____

*Type of pain (Sharp, Dull, Shooting, etc.)*_____

*What makes it better or worse?*_____

_____

*Do you bruise or bleed easily?*_____