



Integrative Hospital Associates

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New Patient Intake Form

Name _____ Date _____

Birthday ___/___/___ Age _____ Male / Female (please circle) Ht/Wt ___/___

Address _____ City, Zip _____

Home Phone _____ Work Phone _____ Occupation _____

Emergency Contact _____ Phone Number _____

Referred by _____

Reason for visit today _____

Have you had complementary medicine before? Yes No Type(s): _____

How long have you had this condition? _____ Does it bother your: Sleep Work Other

What seems to make it better? _____ Worse? _____

Are you under the care of a medical physician? Yes No Physician's name _____

Other current therapies/medications _____

Family Medical History (please check those that apply)

- | | | | | |
|--|---|-----------------------------------|--|---------------------------------------|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Drug Abuse | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> High Blood Pressure | |
| <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Stroke | | |

Your Past Medical History (please check any of the conditions you currently have or have had in the past)

- | | | | | |
|--|--|---------------------------------------|---|--|
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Allergies | <input type="checkbox"/> Anemia | <input type="checkbox"/> Appendicitis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Cancer | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Emphysema |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Goiter | <input type="checkbox"/> Gout | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Herpes | <input type="checkbox"/> Measles | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> Nephritis | <input type="checkbox"/> Pacemaker | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Thyroid Dysfunction | <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Ulcers | <input type="checkbox"/> GI Disorders |
| <input type="checkbox"/> Surgery | | | | |

Injuries

- Broken Bones Concussion or Head Injury Sprains Loss of Consciousness

Please explain _____

Lifestyle

- | | | | | |
|---|----------------------------------|---|---------------------------------|---|
| <input type="checkbox"/> Alcohol | <input type="checkbox"/> Tobacco | <input type="checkbox"/> Drugs | <input type="checkbox"/> Stress | <input type="checkbox"/> Occupational Hazards |
| <input type="checkbox"/> Caffeine- cups/day _____ | | <input type="checkbox"/> Regular Exercise | | |
| | | Type _____ | | |
| | | Frequency _____ | | |

General Symptoms

- | | | | | |
|--|---|---|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Poor sleep | <input type="checkbox"/> Chills | <input type="checkbox"/> Bodily heaviness | <input type="checkbox"/> Bleed or bruise easily |
| <input type="checkbox"/> Heavy appetite | <input type="checkbox"/> Heavy sleep | <input type="checkbox"/> Night sweats | <input type="checkbox"/> Cold hands/feet | <input type="checkbox"/> Peculiar taste (describe) |
| <input type="checkbox"/> Poor circulation | <input type="checkbox"/> Fatigue | <input type="checkbox"/> Lack of strength | <input type="checkbox"/> Dream disturbed sleep _____ | |
| <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Weight loss/gain | <input type="checkbox"/> Fever | <input type="checkbox"/> Muscle cramps | <input type="checkbox"/> Vertigo or dizziness |
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Head, Eyes, Ears, Nose, Throat

- | | | | | |
|--|---|---|---|--|
| <input type="checkbox"/> Glasses | <input type="checkbox"/> Eye strain | <input type="checkbox"/> Red eyes | <input type="checkbox"/> Itchy eyes | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> Night blindness | <input type="checkbox"/> Glaucoma | <input type="checkbox"/> Blurred vision | <input type="checkbox"/> Cataracts | <input type="checkbox"/> Light sensitivity |
| <input type="checkbox"/> Teeth problems | <input type="checkbox"/> Grinding teeth | <input type="checkbox"/> TMJ | <input type="checkbox"/> Facial pain | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> Dry mouth | <input type="checkbox"/> Excessive saliva | <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Excessive phlegm | <input type="checkbox"/> Recurring sore throat |
| <input type="checkbox"/> Lumps in throat | <input type="checkbox"/> Enlarged thyroid | <input type="checkbox"/> Nose bleeds | <input type="checkbox"/> Ringing in ears | <input type="checkbox"/> Poor hearing |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> Migraines | <input type="checkbox"/> Memory loss | <input type="checkbox"/> Fainting | <input type="checkbox"/> Earaches |
| <input type="checkbox"/> Sinus | | | | |
| <input type="checkbox"/> Entire head | | | | |
| <input type="checkbox"/> Back of head | | | | |
| <input type="checkbox"/> Forehead | | | | |
| <input type="checkbox"/> Temples | | | | |
| <input type="checkbox"/> Migraine | | | | |
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Respiratory

- | | | | | |
|--|------------------------------------|---|--|---|
| <input type="checkbox"/> Tight chest | <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Shortness of breath | <input type="checkbox"/> Difficulty breathing when lying down |
| <input type="checkbox"/> Asthma/wheezing | <input type="checkbox"/> Pneumonia | | | |
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Cardiovascular

- | | | | | |
|--|---|---|--|--------------------------------------|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure | <input type="checkbox"/> Heart palpitations | <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Blood clots |
| <input type="checkbox"/> Chest pain | <input type="checkbox"/> Pain around ribs | <input type="checkbox"/> Recent stroke | <input type="checkbox"/> Recent Heart Attack | |
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Gastrointestinal

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|--------------------------------------|---|---|---------------------------------------|---|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Acid reflux | <input type="checkbox"/> Gas | <input type="checkbox"/> Hiccups |
| <input type="checkbox"/> Bloating | <input type="checkbox"/> Bad breath | <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Constipation | <input type="checkbox"/> Laxative use |
| <input type="checkbox"/> Black stool | <input type="checkbox"/> Bloody stool | <input type="checkbox"/> Mucus in stool | <input type="checkbox"/> Itchy anus | <input type="checkbox"/> Intestinal pain/cramps |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Bowel movements: Frequency _____ Color _____ Consistency _____ | | | |
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Musculoskeletal

- | | | | | |
|---|--|--|--|-----------------------------------|
| <input type="checkbox"/> Neck/shoulder pain | <input type="checkbox"/> Low back pain | <input type="checkbox"/> Upper back pain | <input type="checkbox"/> Muscle pain | <input type="checkbox"/> Rib pain |
| <input type="checkbox"/> Joint pain | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Limited use | <input type="checkbox"/> Limited Range of motion | |
| <input type="checkbox"/> Other- describe | | | | |
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Skin and Hair

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|---------------------------------|--------------------------------------|-----------------------------------|---|---|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Eczema | <input type="checkbox"/> Dandruff | <input type="checkbox"/> Changes in hair/skin | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Itching | <input type="checkbox"/> Hair loss | <input type="checkbox"/> Fungal infection |
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Neuropsychological

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|--|---------------------------------------|--|---|---|
| <input type="checkbox"/> Seizures | <input type="checkbox"/> Numbness | <input type="checkbox"/> Tics | <input type="checkbox"/> Poor memory | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Irritability | <input type="checkbox"/> Easily stressed | <input type="checkbox"/> Abuse survivor | <input type="checkbox"/> Suicide attempts |
| <input type="checkbox"/> Seeking a therapist | <input type="checkbox"/> Other _____ | | | |
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Genito-Urinary

- | | | | | |
|---|---|---|---|--|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Blood in urine | <input type="checkbox"/> Venereal disease | <input type="checkbox"/> Increased libido | <input type="checkbox"/> Decreased libido |
| <input type="checkbox"/> Frequent urination | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Bedwetting | <input type="checkbox"/> Impotence | <input type="checkbox"/> Premature ejaculation |
| <input type="checkbox"/> Urgent urination | <input type="checkbox"/> Incomplete urination | <input type="checkbox"/> Wake to urinate | <input type="checkbox"/> Kidney stone | <input type="checkbox"/> Prostate enlargement |
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Gynecology

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|---|---|--|--|---------------------------------------|
| <input type="checkbox"/> Age menses began _____ | <input type="checkbox"/> Duration of flow _____ | <input type="checkbox"/> Vaginal Sores | <input type="checkbox"/> Vaginal ulcers | <input type="checkbox"/> Breast lumps |
| | | <input type="checkbox"/> Irregular periods | <input type="checkbox"/> Cramping | <input type="checkbox"/> PMS |
| <input type="checkbox"/> Hysterectomy | <input type="checkbox"/> Menopause | <input type="checkbox"/> Tumors | <input type="checkbox"/> Pregnancy _____ | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Are you or do you think you are pregnant | | | | |
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