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Patient Intake Form

PATIENT DETAILS

Today's Date

Full Name

Age **Sex** **Social Security #**

Date of Birth

Birth Order

CONTACT INFO

Address of Primary Insured

Address Line 2

City **State**

Postal / Zip Code **Country**

We will send an email confirmation for scheduled appointments.

Mobile Phone

Home Phone

Work Phone

Email

CURRENT MEDICAL TEAM

Primary Physician

Phone Number

OB/GYN

Phone Number

PHARMACY

Preferred Pharmacy

Pharmacy Address

Pharmacy Phone Number

REFERRED BY

Name

EMERGENCY CONTACT

Name **Relationship**

Mobile Phone

Home Phone

INSURANCE

Name of Primary Insured

Relationship to Insured

Date of Birth of Primary Insured

Name of Insurance Carrier

Member ID # **Group ID #**

Address – from the back of your insurance card

HEALTH HISTORY

What brings you to Tula Wellness? What concerns about your health do you have?

What are your health goals?

MEDICAL CONDITIONS

Please list the name and diagnosis date of any current medical conditions.

Please list the name and diagnosis date of any previous or childhood medical conditions.

DIAGNOSTIC STUDIES

Have you ever had diagnostic studies?

Last Date Done & Results (-/+)

Colonoscopy

Bone Density

Electrocardiogram

Other

SURGERIES & HOSPITALIZATIONS

Date	**Procedure**
Date	**Procedure**
Date	**Procedure**

Family Health History

Please tell us about your family. Please include any family member with a history of tuberculosis, diabetes, cancer, emphysema, kidney disease, ulcer, nervous breakdown or gall bladder disease.

Mother

Health Status **Age if Alive/Age at Death** **Cause of Death**

Health Problem

Father

Health Status **Age if Alive/Age at Death** **Cause of Death**

Health Problem

Other family

Health Status **Age if Alive/Age at Death** **Cause of Death**

Health Problem

Additional information related to your Family Medical History you would like us to know:

SOCIAL AND SOCIOECONOMIC HISTORY

Occupation **Employer**

Highest Degree Earned

Do you enjoy your job?

Why? / Why not?

Present Marital Status

Spouse / Partner's Name

Total # in Household, including children

What are your main interests and hobbies?

HABITS & LIFESTYLE

Do you eat breakfast?	☐ **YES**	☐ **NO**
Do you eat three meals a day?	☐ **YES**	☐ **NO**
Do you feel rested upon awakening?	☐ **YES**	☐ **NO**
Do you spend time outside?	☐ **YES**	☐ **NO**
Do you take vacation?	☐ **YES**	☐ **NO**

Average hours per night of sleep

Average hours per day of television

What do you do to relax/recreate/socialize/cope with stress?

What are the major stressors in your life?

When are you happiest? What gives you joy?

Alcohol Use **If yes, what kind?** **If yes, how many per week?**

Tobacco Use **If yes, how many packs?** **If yes, are you interested in quitting?**

Yes

Recreational Drug Use **If yes, what kind?** **If yes, how many per week?**

Have you ever felt that you ought to cut down on your drinking or drug use?

Do you get annoyed at criticism of your drinking or drug use?

Do you ever feel guilty about your drinking or drug use?

Do you ever drink for an early morning "eye opener"?

Do you feel safe in your surroundings?

Do you have a history of sexual abuse?

Describe your energy level throughout a typical day rating on a scale of 1-10:
1=Extreme Fatigue/10=Feeling Great and Energized

- **Early Morning**
- **Mid Morning to Noon**
- **Mid Afternoon**
- **Evening**

Please describe any associated food or drink cravings (sugar, coffee, cola, etc.):

Have you seen a practitioner of alternative medicine?

Never

Please check any practices you have tried:

- ☐ **Acupuncture**
- ☐ **Fasting**
- ☐ **Yoga**
- ☐ **Nutritional Medicine**
- ☐ **Herbal Medicine**
- ☐ **Ayurvedic Medicine**
- ☐ **Naturopathic Medicine**
- ☐ **Neuro-Linguistic Programming**
- ☐ **Orthomolecular Biofeedback**
- ☐ **Chelation Therapy**
- ☐ **Light Therapy**
- ☐ **Homeopathy**
- ☐ **Guided Imagery**
- ☐ **Other**
- ☐ **Hypnosis**
- ☐ **Traditional Chinese Medicine**
- ☐ **Aromatherapy**
- ☐ **Meditation**
- ☐ **Environmental Medicine**
- ☐ **Bodywork**

WOMEN'S HEALTH HISTORY

Date of last menstrual period **Number of children** **Children's ages**

Age at start of periods **Age at end of periods/menopause**

Menses Check all that apply. ☐ **Regular** ☐ **Irregular** ☐ **Painful** ☐ **Other**

History of abnormal pap smears?

If yes, please explain follow-up and treatment you received.

History of breast surgery

If yes, please explain follow-up and treatment you received.

Date of last mammogram

Results of mammogram

Date of last pap smear

Results of pap smear

SEXUAL ACTIVITY

Sexual Orientation

Are you sexually active?

Birth control method

Do you practice safe sex?

ALLERGIES

Do you have an ALLERGY to a drug or other substance?

If yes, please describe.

CURRENT PRESCRIPTION MEDICATIONS

Drug Name **Strength** **Dosage**

SUPPLEMENTS AND OVER-THE-COUNTER

Drug Name **Strength** **Dosage**

IMMUNIZATIONS

☐ Measles/Mumps/Rubella	☐ Polio	☐ Tetanus & Diptheria
☐ Chicken Pox	☐ Pneumovax	☐ Tetanus-Booster
☐ DPT	☐ Influenza	☐ Hepatitis A
☐ Series 1	☐ Series 2	☐ Hepatitis B
☐ Series 1	☐ Series 2	☐ N/A

ANTIBIOTICS

How often have you taken antibiotics?

Infant / Childhood **Teen** **Adult**

Have often have you taken oral steroids?

Infant / Childhood **Teen** **Adult**

TOXIC METALS

Have you ever been exposed to toxic metals in your job or home?

Do you have dental amalgams (silver fillings) or root canals?

EMOTIONAL WELL BEING

How well have things been going for you at school?

How well have things been going with close friends?

How well have things been going for with your children?

How well have things been going for you at your job?

How well have things been going for you with sex?

How well have things been going for you with your parents?

How well have things been going for you with your social life?

How well have things been going for your attitude?

How well have things been going for you with your spouse/partner?

NUTRITION EVALUATION

Please list all foods and drinks you have consumed in the past 24 hours. Include meals, snacks, beverages and condiments.

Food Items; How Prepared (Baked, Fried, etc.); Amount (Cups, Tablespoons, Ounces, etc.):

Is this a typical day?

How many servings of fruit do you eat/drink each day? Serving = 1 small piece of fruit, 1 cup canned or chopped fruit, 1 cup dried fruit.

Are you currently on a special diet?

If yes, please describe:

Do you eat red meat?

What kind?

How many times per week?

Do you have symptoms immediately after eating such as belching, bloating, sneezing, hives, etc.?

If yes, are these symptoms associated with any particular food or supplements?

Please name the food or supplement and the symptom(s); i.e. Milk = gas,diarrhea

Do you feel you have delayed symptoms after eating certain foods? (symptoms may not be evident for 24 hours or more) such as fatigue, muscle aches, sinus congestion, etc.)

Does skipping a meal greatly affect your symptoms?

Is there anything about your diet that we should know?

Have you ever had a food that you craved or really "binged" on over a period of time? (Food craving might be an indicator that you are allergic to that food)

If yes, what food?

Do you have an aversion to certain foods?

If yes, what foods?

REVIEW OF SYSTEMS

Please check any current symptoms you may have:

Constitutional

- ☐ Recent Fever
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ Unexplained Weight Loss/Gain
- ☐ Decline in Libido

Cardiovascular

- ☐ Chest Pain/Discomfort
- ☐ Palpitations
- ☐ Short of Breath with Exertion

Respiratory

- ☐ Cough/Wheeze
- ☐ Coughing up Blood

Genitourinary

- ☐ Painful/Bloody Urination
- ☐ Leaking Urine
- ☐ Nighttime Urination
- ☐ Unusual Vaginal Bleeding
- ☐ Concern with Sexual Function

Skin

- ☐ Rash
- ☐ New or Change in Mole
- ☐ Thin, Ridged or Splitting Nails

Gastrointestinal

- ☐ Heartburn/Reflux
- ☐ Blood or Change in Bowel Movement
- ☐ Nausea/Vomitting/Diahhrea
- ☐ Pain in Abdomen
- ☐ Irritable Bowel Syndrome/Digestive Problems

Psychiatric

- ☐ Anxiety/Stress
- ☐ Sleep Problems
- ☐ Depression
- ☐ Irritability

Eyes

- ☐ Changes in Vision

Blood/Lymphatic

- ☐ Unexplained Lumps
- ☐ Easy Bruising/Bleeding

Neurological

- ☐ Headaches
- ☐ Memory Loss
- ☐ Fainting

Ear/Nose/Throat

- ☐ Difficulty Hearing
- ☐ Hay Fever/Allergies
- ☐ Trouble Swallowing

Musculoskeletal

- ☐ Muscle/Joint Pain
- ☐ Recent Back Pain

Endocrine

- ☐ Cold/Heat Intolerance
- ☐ Increased Thirst/Appetite

MEDICAL SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the last 30 Days.

Point system:

0 = Never or almost never have the symptoms

1 = Occasionally (effect is not severe)

2 = Occasionally (effect is severe)

3 = Frequently (effect is not severe)

4 = Frequently (effect is severe)

At the bottom of each section, total the numbers from the symptoms. At the very end, tally the grand total.

HEAD

Headaches **Faintness** **Dizziness** **Insomnia**

Total

← Add all the numbers in the HEAD section here

DIGESTIVE

Nausea/Vomiting/Diarrhea **Constipation** **Bloated Feeling** **Belching/Passing Gas**

Heartburn **Intestinal/Stomach Pain**

Total

← Add all the numbers in the DIGESTIVE section here

EYES

Watery/Itchy Eyes **Swollen, Reddened or Sticky Eyelids** **Bags or Dark Circles** **Blurred or Tunnel Vision – not near- or far-sightedness**

Total

← Add all the numbers in the EYES section here

EARS

Itchy Ears **Ear Aches or Infections** **Drainage from Ear** **Ringing/Hearing Loss**

Total

← Add all the numbers in the EARS section here

WEIGHT

Binge Eating/Drinking **Craving Certain Foods** **Compulsive Eating** **Water Retention**

Underweight

Total

← Add all the numbers in the WEIGHT section here

ENERGY/ACTIVITY

Fatigue/Sluggishness **Apathy/Lethargy** **Hyperactivity** **Restlessness**

Total

← Add all the numbers in the ENERGY/ACTIVITY section here

NOSE

Stuffy Nose 0

Sinus Problems 0

Hay Fever 0

Sneezing Attacks 0

Excessive Mucus Formation 0

Total

← Add all the numbers in the NOSE section here

MIND

Confusion/Poor Comprehension

Poor Memory

Poor Concentration

Poor Physical Condition

Difficulty Making Decisions

Stuttering or Stammering

Slurred Speech

Total

← Add all the numbers in the MIND section here

EMOTIONS

Mood Swings

Anxiety/Fear/Nervousness

Anger/Irritability

Depression

Total

← Add all the numbers in the EMOTIONS section here

SKIN

Acne

Hives/Rashes/Dry Skin

Hair Loss

Excessive Sweating

Flushing/Hot Flashes

Excessive Sweating

Total

← Add all the numbers in the SKIN section here

JOINTS/MUSCLES

Pain or Aches in Joints

Arthritis

Stiffness/Limitation of Movement

Feeling of Weakness or Tiredness

Total

← Add all the numbers in the JOINTS/MUSCLES section here

OTHER

Frequent Illness **Frequent or Urgent Urination** **Genital Itch or Discharge**

Total

← Add all the numbers in the FREQUENT ILLNESS section here

GRAND TOTAL

← Add all the TOTALS together here

Signature

Date