Today's Date _____ **PATIENT INTAKE FORM** Date of Birth _____

Name _____ Phone: Home _____ Cell _____
Street _____ City _____ ST _____ Zip _____
Occupation_____ Last Physical Exam_____ Ht: _____ Wt: _____ Age:_____
Your Email:_____ How did you hear about us?_____
What are chief health concerns?_____
Current Medicines/Prescriptions:_____
Allergies (drugs, chemicals, foods, environmental): _____
_____

Habits: ☐ Cigarettes; ☐ Coffee; ☐ Tea; ☐ Soda; ☐ Alcohol; ☐ Recreational Drugs; ☐ Antacids; ☐ Laxatives

Personal and Family Health History:

Key: **Self**: C = Current, P = Past **Family**: M = Mother, F = Father, S = Sibling, C = Offspring

Disease:	**Self:**	**Family:**	**Disease:**	**Self:**	**Family:**
Herpes			Thyroid disease		
Arthritis			Gout		
Bursitis /sciatica			Depression		
Chronic Back issues			Anxiety		
Epilepsy/seizures			Eating Disorder		
Anemia			Substance abuse		
Gall Bladder Disease			Chronic fatigue		
Liver disease/hepatitis			Fibromyalgia		
IBS (irritable bowel)			Vertigo		
Inflammatory colitis			Heart murmur		
Candida			Heart disease		
Hemorrhoids			High blood pressure		
Heartburn			High cholesterol		
Stomach ulcers			Stroke/thrombosis/clots		
Hiatal hernia/reflux/GERD			Obesity		
Diverticulosis/it is			Diabetes		
Prostatitis/BPH			Cancer		
Kidney stones			Autoimmune condition		
Urinary tract infections			Osteoporosis/osteopenia		
Sexually transmitted infections			Migraines/headaches		
Yeast infection			Chronic sinus infections		
Menopause			Acne		
Menstrual issues			Eczema/psoriasis/hives		
PMS			Asthma		
Endometriosis			Hayfever/environmental allergies		
Fibroids			Lyme disease/tickborn disease		
Infertility			Shingles		
Erectile dysfunction			Parkinson's disease		