LOVE YOUR BODY

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New Patient Intake Form

Name: _____ Age: _____ Occupation: _____

Home Phone: _____ Height: _____ Email: _____

Work Phone: _____ Weight: _____ Physician: _____

Street: _____ Birthdate: _____ Referred By: _____

City: _____ Sex: _____ Emerg. #: _____

State: _____ Zip: _____ Marital Status: _____

Main Problem: _____

Onset: _____ Other Concurrent Therapies: _____

Past Medical History - *Significant Illnesses*:

☐ Cancer ☐ Diabetes ☐ High Blood Pressure ☐ Heart Disease ☐ Hepatitis ☐ Rheumatic Fever

☐ Thyroid Disease ☐ Seizures ☐ Other: _____

Surgeries: _____

Significant Trauma (auto accidents, falls, etc.) _____

Birth History (prolonged labor, forceps delivery, etc.): _____

Allergies (drugs, chemicals, foods): _____

Medicines taken within the last two months: _____
(include vitamins, over-the-counter drugs, herbs, etc.)

Occupational Stresses: _____
(Chemical, physical, psychological, etc.)

Exercise: _____

Average daily diet:

Morning: _____ *Afternoon:* _____ *Evening:* _____

Habits: ☐ Cigarettes ☐ Coffee ☐ Tea ☐ Cola ☐ Alcohol ☐ Drugs ☐ Sugar ☐ Salt

Other: _____

Family Medical History: ☐ Diabetes ☐ Cancer ☐ High Blood Pressure ☐ Heart Disease

☐ Stroke ☐ Seizures ☐ Asthma ☐ Allergies ☐ Alcoholism Other: _____

General:

☐ Poor appetite
☐ Heavy appetite
☐ Poor sleep
☐ Heavy sleep
☐ Insomnia

☐ Fatigue
☐ Tremors
☐ Vertigo
☐ Cold hands
☐ Cold feet

☐ Cold back
☐ Cold abdomen
☐ Fevers
☐ Chills
☐ Night sweats

☐ Sweat easily
☐ Cravings
☐ Localized weakness
☐ Poor coordination
☐ Change in appetite

☐ Peculiar tastes/smells _____
☐ Bleed or bruise easily (where) _____
☐ Strong thirst (cold/hot drinks) _____
☐ Sudden energy drop at (time) _____

Skin & Hair:

☐ Rashes
☐ Ezcema
☐ Other: _____

☐ Pimples
☐ Purpura

☐ Dandruff
☐ Loss of hair

☐ Changes in hair/skin texture

Head, Eyes, Ears, Nose, and Throat:

- ☐ Dizziness
- ☐ Eye Strain
- ☐ Color blindness
- ☐ Ringing in the ears
- ☐ Mucus
- ☐ Teeth Problems
- ☐ Gum Problems
- ☐ Sores on lips or tongue
- ☐ Concussions
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Dry throat
- ☐ Jaw clicks
- ☐ Spots in the eyes
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Nose bleeds
- ☐ Dry mouth
- ☐ Grinding teeth
- ☐ Glasses
- ☐ Night blindness
- ☐ Earaches
- ☐ Sinus problems
- ☐ Copius saliva
- ☐ Facial pain
- ☐ Headaches (when and where): _____
- ☐ Rucurrent sore throat: _____ / times a month
- ☐ Other: _____

Cardiovascular:

- ☐ High blood pressure
- ☐ Dizziness
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Phlebitis
- ☐ Chest pain
- ☐ Cold hands/feet
- ☐ Difficulty breathing
- ☐ Irregular heartbeat
- ☐ Swelling hands/feet
- ☐ Other: _____

Respiratory:

- ☐ Cough
- ☐ Pneumonia
- ☐ Coughing blood
- ☐ Tight Chest
- ☐ Asthma
- ☐ Bronchitis
- ☐ Difficulty in breathing when lying down
- ☐ Production of phlegm (what color) _____
- ☐ Other: _____

Gastrointestinal:

- ☐ Nausea
- ☐ Gas
- ☐ Bad breath
- ☐ Constipation
- ☐ Pain or cramps
- ☐ Vomiting
- ☐ Belching
- ☐ Rectal pain
- ☐ Bloody stools
- ☐ Diarrhea
- ☐ Black stools
- ☐ Hemorrhoids
- ☐ Laxative use: _____ / week; Type: _____
- ☐ Sensitive abdomen

Bowel movement Frequency: _____ Color: _____ Odor: _____ Texture/Form: _____

Genito-Urinary:

- ☐ Pain on urination
- ☐ Unable to hold urine
- ☐ Frequent urination
- ☐ Kidney stones
- ☐ Blood in urine
- ☐ Veneral disease
- ☐ Urgency to urinate
- ☐ Impotency
- ☐ Wake up to urinate (how often) _____ /night; time: _____
- ☐ Other: _____

Pregnancy & Gynecology:

of pregnancies _____
# of births _____
Miscarriages _____
Premature births _____
Age at first menses _____
Period duration (days) _____
Last menses _____
Menopause _____

- ☐ Clots
- ☐ Vaginal sores
- ☐ Irregular periods
- ☐ Breast lumps
- ☐ Vaginal discharge
- ☐ Changes in body/ psyche prior to menstruation

Birth control type and duration: _____

Musculo-Skeletal:

- ☐ Neck pain
- ☐ Muscle pain
- ☐ Back pain (where)
- ☐ Joint pain (where)
- ☐ Other: _____

Neuropsychological:

- ☐ Seizures
- ☐ Depression
- ☐ Treated for emotional problems
- ☐ Areas of numbness
- ☐ Anxiety
- ☐ Poor memory
- ☐ Bad temper
- ☐ Concussion
- ☐ Easily stressed
- ☐ Considered/attempted suicide
- ☐ Other: _____

Comments: _____