Intake form

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HEALTH HISTORY

Name____ Date___________

Address ____

____

Phone (H) ________________ Phone(W)___________________

Weight ______________ Height _______Age_______

Birth Date________ Occupation_________________ Marital Status______

Referred by_________________ Primary Health Care Provider___________________

Reason for consultation____

Family Health History

1. Indicate present health condition of (**or age & cause of death**):

maternal grandmother__________________ paternal grandmother__________________

maternal grandfather___________________ paternal grandfather___________________

mother______________________________ father______________________________

sisters______________________________ brothers____________________________

2. Who in your family has or had any of the following?**(M=mother, F=father, A=aunt, etc)**

alcoholism_____________________________ allergies_______________________________

arthritis_____________________________ asthma______________________________

cancer______________________________________ diabetes__________________________________

eating disorder___________________________ emphysema_____________________________

glaucoma___________________________ heart disease________________________

high blood pressure_____________________ kidney disease________________________

mental illness_________________________ obesity______________________________

tuberculosis______________________________ other___________________________________

Personal Health History

1. Check any of the following conditions which you now have or have had in the past:

abscesses	AIDS/ARC	alcoholism	allergies	anemia	anorexia
	arthritis	asthma	bloating	bulimia	cancer
colitis/lBS	compulsive eating	depression	dermatitis	diabetes	diverticulitis
emphysema	fatigue	fibromyalgia	gas	gastritis	headaches
heartburn	heart disease	hepatitis	hernia	hypertension	hypoglycemia
insomnia	jaundice	kidney disease	mental illness	mononucleosis	obesity
pain	pneumonia	rheumatic fever	sexually transmitted disease	smallpox	stroke
thyroid disorder	tonsilitis	tuberculosis	ulcer	visual problems	other

NAME= ___________________________

2. Do you have any problems with your skin, hair or nails? ____

3. Do you have any problems with your teeth, bite or gums?____
4. List all surgery you have had (include dental): ____
____

5. Women, answer these questions about your menstrual cycle and reproductive history

- age at onset of menstruation____
- how often menstruation occurs____
- how long menstruation lasts____
- premenstrual symptoms____
- symptoms during menstruation____
- frequency of napkin or tampon change on heaviest day____
- drug/hormone therapy related to menstrual cycle____
- age at onset of menopause____
- how long menopause lasted (if ended)____
- symptoms during menopause____
- drug/hormone therapy during menopause____
- number of pregnancies____
- number of miscarriage____ ________
- number of children (include ages)____
- number of abortions ____
- drug therapy related to pregnancy (include DES)____
- birth control methods____
- vaginitis____
- last pap smear____
- last breast exam____

6. Answer these questions about your early life, if you can:

- drugs your mother took during pregnancy____
- foods your mother craved during pregnancy____
- mother’s alcohol consumption during pregnancy____
- were you breastfed ____
- age at which you were weaned, if breastfed____
- state of health as infant_____________________ ____
- state of health as child______________________ ____
- state of health as teen ______________________ ____
- state of health as young adult____

7. Mention any emotional or other traumas in your life that may have influenced your health:_______________
____
8. Indicate the amount of daily consumption of:
meals____
water____
alcohol____

tobacco____

NAME= ___________________________

coffee____

tea (include iced tea)___________________________________

soft drinks/diet soda____________________________________

sweets____

sugar substitutes_______________________________________

salty snacks ____

9.Indicate average number per day of:

hours of sleep____

bowel movements_______________________________________

urination ____

10. Answer these questions about your elimination:

Do you have diarrhea?_______How often?__________________________

Are you sometimes constipated?___________ How often?______________

Is your elimination painful?_______________________________________

Do your stools vary with diet?_____________________________________

Do your stools vary with emotional state?___________________________

11. List all prescription drugs, over-the-counter drugs, recreational drugs, vitamins, herbs or homeopathic remedies you are currently taking:____

____

What have you previously taken:____

12. What health care providers(include alternative) are you currently seeing________________________________

____

Who have you seen in the past:____

13. Are you satisfied with your weight?_______________________

Give a brief description of your weight history:____

____

____

14. What do you do for exercise?____

15. What do you do to relax?________________________________ ______________________________________

16. How would you rate your energy level?____

17.How would you rate your overall health? ____

18.What are the major stressors in your life______________________________________

____

19. What aspects of your life do you see as nourishing?______________________________________

____

20.What are your long-term health goals?____

____

21. Anything else you’d like to add:

Section 2: NUTRITION INTAKE

NAME= ____________________________

1. Are there any foods you avoid for health reasons?

2. Do you have problems with: indigestion, belching gas, bloating?

3. Eating:

- How is your appetite?
- How is your thirst?
- What are your favorite foods?
- What are your least-liked foods?
- Do you enjoy eating?
- Do you feel that your diet is deficient in any way? How__________
- Do you feel your diet is excessive in any way?

4. Who cooks your food?

- If you do, do you enjoy cooking?
- Who does the shopping in your household?
- Where do you shop?

5. What is mealtime like in your household? **(What & When)**

breakfast : **lunch:** **dinner:**

- What were mealtimes like in your household growing up

breakfast **lunch** **dinner**

- Did you learn any food rules from your family?

6. Do feelings make you eat a certain way?____

____

Does eating make you feel a certain way?____

____

7. Describe your weight history.____

____

8. Describe your eating history.____

Section3: **HOW HAVE YOU FELT IN THE PAST 30 DAYS ?**

Name = ____________________________

0 Circle any of the following that apply to you.

Nausea or vomiting	Itchy ears	Mood swings
Diarrhea	Earaches. ear infections	Anxiety, fear or nervousness
Constipation	Drainage from ears	Anger or irritability
Bloating	Ringing in ears	Depression
Belching or passing gas	Hearing loss	Headaches
Heartburn or indigestion	Watery or itchy eyes	Faintness
Fatigue. sluggishness	Swollen or reddened eyelids	Dizziness
Apathy. lethargy	Bags or dark circles under eyes	Insomnia
Hyperactivity	Blurred vision	Irregular or skipped heartbeat
Restlessness	Chest congestion	Rapid or pounding heartbeat
Pain or aches in joints	Asthma, bronchitis	Chest pain
Pain or aches in muscles	Shortness of breath	Varicose veins
Back pain	Difficulty breathing	Hemorrhoids
Foot or leg cramps	Stuffy nose	Poor memory
Arthritis	Sinus problems	Confusion
Stiffness	Hay fever	Poor concentration
Limitation of movement	Sneezing attacks	Poor physical coordination
Muscle weakness or tiredness	Excessive mucus formation	Difficulty making decisions
Slow wound healing	Chronic coughing	Stuttering or stammering
Bruise easily	Gagging	Slurred speech
Nail problems	Frequent need to clear throat	Binge eating
Acne	Sore throat	Binge drinking
Hives, rashes or dry skin	Hoarseness or loss of voice	Craving certain foods
Hair thinning or loss	Canker sores	Excessive weight
Flushing or hot Hashes	Swollen tongue, gums or lips	Compulsive eating
Excessive sweating	Discolored tongue, gums, lips	Underweight
Menstrual pain	Frequent illness	Water retention
Menstrual irregularity	Frequent or urgent urination	Cold hands and feet
PMS	Genital itch or discharge	Heavy menstrual bleeding

Sheila12/12/2002