New Patient Intake Form

Patient Name:____ Date:________________

Date of Birth:______________ Current Age:_________

Street Address:____

City:___________________ State:__________ Zip:__________

Home phone: ______________Work Phone:_____________Cell Phone:______________

Email____

Highest level of education:________________________

Occupation:________________Employer________________Hours work per week:_____

Marital Status (circle):Single Married Separated Divorced With Partner Widow(er)

Person to call in case of Emergency:____

Relationship to you:____

Phone number contact for them:__________________________________

Regular Physician: ________________________________

How did you hear about Tiffany:____

List in Order of Importance what your problems are:

1.

2.

3.

4.

5.

Last time you had blood work done and with what doctor:__________________________

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Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	______	_____	______	_________	______	_______
Age when died	______	_____	______	_________	______	_______
Reason for death	______	______	______	_________	______	________
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

1. ____________________________ 4. ________________________________
2. ____________________________ 5. ________________________________
3. ____________________________ 6. ________________________________

Please Note When and Why You Had Each of The Following:

X-rays: ____

MRI/Cat Scans:____

Ultrasounds:____

Accidents:____

List All Sensitivities/Allergies/Reactions

Drugs: ____________________________________

Foods: ____________________________________

Environment: _______________________________

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diptheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions:____

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List Yes, No, or Past regarding use of the following:

Antacids: Y N P Steroids: Y N P
Smoking: Y N P Packs per day if Yes/Past:__________
Analgesics: Y N P Laxatives: Y N P
Coffee: Y N P Cups per day if Yes/Past:___________
Soda Pop: Y N P Ounces per day if Yes/Past:___________
Alcohol: Y N P How often and how much if Yes/Past:___________
Any alcohol addiction: Y N P
Any alcohol treatment: Y N P
Recreational drugs: Y N P
Any drugs addiction: Y N P
Any drug treatment: Y N P

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

____
____
____
____
____
____

Review Of Systems:

Present Weight:______________ Weight one year ago: _________________
Height: ________________ Maximum weight and when:____________
Minimum Weight as adult and when: ______________
Ideal Weight:____________

REGARDING THE NEXT SECTION: Please Circle Y (for YES) if you have the problem NOW, N if you've NEVER had the problem, P if you had the problem in the PAST.

Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst?:_________
If you have fatigue, can you do what you need to during the day?: Y N

Skin:

Rash: Y N P Color Change: Y N P
Hives: Y N P Lump: Y N P
Psoriasis/eczema: Y N P Itchy: Y N P
Dry: Y N P Warts/moles: Y N P

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Cancer:	Y N P	Perspiration:	Y N P

Head:

Headache:	Y N P	Migraine:	Y N P
Dandruff:	Y N P	Head Injury:	Y N P
Oil/dry hair:	Y N P	Hair loss:	Y N P

Eyes:

Dry/Watery:	Y N P	Blurry vision:	Y N P
Double vision:	Y N P	Cataracts:	Y N P
Glaucoma:	Y N P	Styes:	Y N P
Strain:	Y N P	Discharge:	Y N P
Itchy:	Y N P	Dark under eyelid:	Y N P

Nose:

Frequent colds:	Y N P	Nosebleeds:	Y N P
Congestion:	Y N P	Post nasal drip:	Y N P
Polyps:	Y N P	Seasonal allergies:	Y N P

Mouth/Throat:

Canker sores:	Y N P	Cold sores:	Y N P
Sore throat:	Y N P	Gum disease:	Y N P
Dentures:	Y N P	Cavities:	Y N P
Loss of taste:	Y N P	Hoarseness:	Y N P

Neck:

Stiffness:	Y N P	Swollen glands:	Y N P
Full movement:	Y N P	Tension:	Y N P

Respiratory:

Cough:	Y N P	TB:	Y N P
Shortness of breath with exertion:	Y N P	Bronchitis:	Y N P
Shortness of breath sitting:	Y N P	Pneumonia:	Y N P
Shortness of breath lying down:	Y N P	Asthma:	Y N P
Wheezing:	Y N P	Painful breathing:	Y N P

Cardiovascular:

High blood pressure:	Y N P	Rheumatic Fever:	Y N P
Low blood pressure:	Y N P	Murmurs:	Y N P
Arrhythmias:	Y N P	Palpitations:	Y N P

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Edema: Y N P

Chest pain: Y N P

Gastrointestinal:

Heartburn: Y N P
Indigestion: Y N P
Bloating: Y N P
Nausea : Y N P
Vomiting: Y N P
Change in Appetite: Y N P
Pancreatitis: Y N P

Bowel movement frequency:______
Recent change in BM: Y N P
Diarrhea or constipation: Y N P
Hemorrhoids: Y N P
Gall bladder disease: Y N P
Liver disease: Y N P
Ulcer: Y N P

Urinary Tract:

Incontinence: Y N P
Frequent infections: Y N P
Urgency: Y N P

Pain with urination: Y N P
Kidney stones: Y N P
Discharge/blood: Y N P

Male:

Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P
Impotency: Y N P

Sexually active: Y N P
Sexually transmitted disease:Y N P
Prostate disease/symptoms: Y N P
Sexual orientation: Hetero Homo Bi

Female:

Age periods began:______________
How long periods last: ____________
Periods:
Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P
Last Pap Smear:___________
Diagnosis: __________
Any abnormal paps: Y N P
When was abnormal: Y N P

How often periods occur:_________
Menopausal since what age:_______
Times Pregnant:__________
How many births:_________
Miscarriages:____________
Abortions:___________
Sexual Active: Y N P
Healthy Libido: Y N P
Pain With Intercourse: Y N P
Dry Vagina: Y N P
Vaginitis: Y N P

Any Birth Control (please list types and ages used):____________________________
Sexually Transmitted Diseases: Y N P
Mammography: Y N P
Dexa Scan: Y N P If Yes, what were the results:_________
Use of Hormones: Y N P

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Musculoskeletal:
Weakness: Y N P
Stiffness: Y N P
Tremors: Y N P
Arthritis: Y N P
Leg cramps: Y N P
Pain: Y N P

Nervous:
Paralysis: Y N P
Tingling/numbness: Y N P
Seizures: Y N P
Sciatica: Y N P
Carpal tunnel syndrome: Y N P
Fainting: Y N P

Mental/Emotional:
Depression: Y N P
Suicidal: Y N P
Anxiety: Y N P
Anger/irritability: Y N P
High-strung/tense: Y N P
Fear/Panic: Y N P

Exercise:
How often:________________________________
What type(s):______________________________
For How long:_____________________________

Hobbies:
____
____

Sleep:
How long per night: _______________________
If you wake up frequently, what is the reason: ___________________________
Nightmares: Y N P
Wake refreshed:Y N P
Must Nap during the day: Y N P
Sleep walk: Y N P
Grind Teeth: Y N P
Snore: Y N P

Food:
Appetite Good?: Y N P
Foods crave: ______________________________
Foods Dislike: _____________________________
Foods that don't sit well:_____________________

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Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:____

Are you particularly sensitive to perfumes, gasoline, or other vapors?:__________________

Do you use pesticides, herbicides, other chemicals around your home?_________________

____

Social Life:

Enjoy job?: Y N P

Active Spiritual practice: Y N P

Quality of most significant relationship?______________________________

History of sexual, mental/emotional, physical abuse?: Y N

If so, at what age and by whom?: ____

What is your greatest health concern?____

____

How does it limit you the most?

____

How committed are you towards making valuable changes: Little Moderately Very

Please use the rest of the page to write any additional you comments you may have about the reason for your visit.

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