Vital Intake Form

Full Name:

Date:

Address:

Telephone: (home):

(cell):

Is it okay to leave a message on your home and cell phone?

Email:

Age:

Date of birth:

Gender:

Relationship status:

Living with:

Occupation (include hours per week):

How did you hear about this clinic?

Has any other family member been a patient at this clinic?

Emergency contact: Relationship:

Emergency contact telephone:

Emergency contact address:

Context of Care Review

Successful healthcare and preventative medicine are only possible when the physician has a

comprehensive understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in advancing your physician's understanding of you and your health goals. Your time, thoughtfulness, and honesty in completing this review will greatly aid your physician in meeting your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit?

What *long term* expectations do you have from working with our clinic?

What expectations do you have from me personally as your healthcare provider?

What is your present level of commitment in addressing any underlying causes of your signs and symptoms that may relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed:

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you regularly engage in that you believe support your health?

What behaviors or lifestyle habits do you regularly engage in that you believe harm your health?

What potential obstacles do you foresee in addressing the lifestyle factors that may be undermining your health and adhering to the therapeutic protocols that I will be sharing with you?

Who do you know that will sincerely and consistently support you with the lifestyle changes you will be making?

What do you love to do?

Medical History Intake

Are you currently receiving healthcare? Yes or No

If yes, where and from whom:

If no, when and where did you last receive medical or healthcare?

What was the reason you sought healthcare?

What are your most important health problems? List as many as you can in order of importance.

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

Do you have any contagious disease that you know of at this time? Yes or No

If yes, what? And have you received treatment?

FAMILY & PAST MEDICAL HISTORY:

Do you or anyone in your family have a history of the following diseases? Please circle and indicate who.

Cancer Diabetes Heart Disease High Blood Pressure
Kidney Disease Epilepsy Arthritis Glaucoma
Tuberculosis Stroke Anemia Mental Illness
Asthma Hay Fever Hives Thyroid Disease

Any other relevant family history?

What is your family heritage?

CHILDHOOD ILLNESSES:

Weight at birth if known:

Please circle whether you had any of the following as a child:

Rheumatic Fever Diptheria Scarlet Fever Chicken pox
German Measles Measles Mumps

HOSPITALIZATIONS/SURGERY/IMAGING:

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

______________________________ year _________ ______________________________ year __________

______________________________ year ________ ____________________________ year _________

ALLERGIES:

Are you hypersensitive or allergic to:

Any drugs?

Any foods?

Any environmental or chemical allergies?

CURRENT MEDICATIONS:

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are currently taking:

1. _______________________________________ 5. ____
2. _______________________________________ 6. ____
3. _______________________________________ 7. ____
4. _______________________________________ 8. ____

GENERAL

Height: Weight: Weight one year ago:

Maximum Weight: When:

When during the day is your energy the best? Worst?

Main interests and hobbies:

Exercise: Yes or No, If so, what kind and how often?

Watch TV: Yes or No, If so, how many hours per day?

Read: Yes or No, If so, how many hours per day?

Spiritual or Religious Practice? If so, what kind?

TYPICAL FOOD INTAKE:

Breakfast:

Lunch:

Dinner:

Snacks:

To drink (include amounts per day):

Water:

Beer:

Wine:

Liquor:

Metabolic Assessment form

For the following Metabolic Assessment, please Circle:

Y= A condition you have now **N**= Never had **P**= A significant problem in the past **S**= Sometimes a problem

General

Do you sleep well?	Y N P S
Average 6-8 hrs?	Y N P S
Awake rested?	Y N P S
Have a supportive relationship?	Y N P S
Have a history of abuse?	Y N P S
Experienced a major trauma?	Y N P S
Use recreational drugs?	Y N P S
Treated for drug dependence?	Y N P S
Use alcoholic beverages?	Y N P S
Use tobacco?	Y N P S
In the past, how many years?	_________
How many packs/cans per day?	_________
Do you enjoy your work?	Y N P S
Take vacations?	Y N P S
Spend time outside?	Y N P S
Eat three meals a day?	Y N P S
Do you go on diets often?	Y N P S
Do you drink coffee?	Y N P S
Drink black/green tea?	Y N P S
Drink soda?	Y N P S
Do you eat refined sugar?	Y N P S
Do you add salt to your food?	Y N P S

Neurologic

Seizures?	Y N P S
Muscle weakness?	Y N P S
Loss of memory?	Y N P S
Vertigo or dizziness?	Y N P S
Paralysis?	Y N P S
Numbness or tingling?	Y N P S
Easily stressed?	Y N P S
Loss of balance?	Y N P S

Ears

Impaired hearing?	Y N P S
Ringing in ears?	Y N P S
Dizziness?	Y N P S
Ear aches?	Y N P S

Eyes

Impaired vision?	Y N P S
Cataracts?	Y N P S
Glaucoma?	Y N P S
Spots in vision?	Y N P S
Color blindness?	Y N P S
Tearing or dryness?	Y N P S
Eye pain or strain?	Y N P S

Head

Headaches?	Y N P S
Migraines?	Y N P S
Head injury?	Y N P S
Jaw or TMJ problems?	Y N P S

Nose and Sinus

Frequent colds?	Y N P S
Stuffiness?	Y N P S
Sinus problems?	Y N P S
Nose bleeds?	Y N P S
Hay fever?	Y N P S
Loss of smell?	Y N P S

Neck

Lumps in neck?	Y N P S
Goiter?	Y N P S
Difficulty swallowing?	Y N P S
Pain or stiffness in neck?	Y N P S

Endocrine

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S
Hyperthyroid?	Y	N	P	S
Diabetes?	Y	N	P	S
Excessive hunger?	Y	N	P	S
Seasonal sadness?	Y	N	P	S
Difficulty exercising?	Y	N	P	S

Immune

Reactions to immunizations?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S
Slow wound healing?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S
Chronic infections?	Y	N	P	S
Night sweats?	Y	N	P	S

Mouth and Throat

Frequent sore throats?	Y	N	P	S
Copious saliva?	Y	N	P	S
Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Jaw clicks?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

Skin

Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Eczema or hives?	Y	N	P	S
Itching?	Y	N	P	S
Perpetual hair loss?	Y	N	P	S

Respiratory

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Shortness of breath when lying down?	Y	N	P	S
Pain with breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S

Gastrointestinal

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Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/Vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall Bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S

Symptoms:_____________________________________

Hemorrhoids?	Y	N	P	S

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Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S

Bowel movements: how often?________________

Is this a change?______________________________

Muskculoskeletal cont.

Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S

Blood

Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

Female Reproductive

Age of first menses:

Age of last menses (if menopausal):___________

Length of cycle:_____________________ days

Duration of menses:_________________ days

Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S
Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S

Date of last pap smear:_________________________

Black stools? Y N P S
Blood in stool? Y N P S

Mental & Emotional
Treated for emotional problem? Y N P S
Depression? Y N P S
Anxiety or nervousness? Y N P S
Poor concentration? Y N P S
Do you have mood swings? Y N P S
Considered suicide? Y N P S
Attempted suicide? Y N P S
Tension? Y N P S
Memory problems? Y N P S

Abnormal PAP? Y N P S
Cervical dysplasia? Y N P S
Are you sexually active? Y N P S
Sexual orientation:___________________________
Birth control? Type:__________________________
Pain during intercourse? Y N P S
Gonorrhea? Y N P S
Herpes? Y N P S
Chlamydia? Y N P S
Genital warts? Y N P S
Syphilis? Y N P S
Difficulty conceiving? Y N P S
Number of pregnancies:_______________________
Number of live births:_________________________
Number of miscarriages:______________________
Number abortions:___________________________

Urinary
Increased frequency of urination? Y N P S
Inability to hold urine? Y N P S
Pain with urination? Y N P S
Frequency at night? Y N P S
Frequent UTI's? Y N P S
Kidney stones? Y N P S

Do you do self breast exams? Y N P S
Breast pain/tenderness? Y N P S
Breast lumps? Y N P S
Nipple discharge? Y N P S
Menopausal symptoms? Y N P S

Muskculoskeletal
Joint pain or stiffness? Y N P S
Arthritis? Y N P S
Broken bones? Y N P S

Male Reproductive
Are you sexually active? Y N P S
Sexual orientation:___________________________
Birth control? Type:__________________________

Male Reproductive Cont.
Discharge or sores? Y N P S
Chlamydia? Y N P S
Gonorrhea? Y N P S
Genital warts? Y N P S
Herpes? Y N P S
Syphilis? Y N P S
Hernias? Y N P S
Testicular masses? Y N P S
Testicular pain? Y N P S
Prostate disease? Y N P S
Impotence? Y N P S
Premature ejaculation? Y N P S
Decreased libido? Y N P S
Increased libido? Y N P S