Consultation Intake Form

Date: ______________

Name: ____ Age:________ Sex: M F T
Address: ____
Phone: (day)______________________________ (evening)____________________________________
e-mail:____ Birth date: __________________________

What would you like help with at this time?

____
____
____

Present physical complaints: ____
____
____

Onset and length of symptoms: ____
____
____

At or around the time of onset were other emotional or physical stresses occurring?

____

List any medications you are presently taking: ____
____

List any Herbal Medicines, Supplements, Homeopathics, and Over the Counter Medications you are presently taking:

Medication/Herb/Etc.	Reason for Use	Dosage	Times a day

Please bring all vitamins, herbs, supplements, over the counter and prescription medications with you to your appointment.

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PAST MEDICAL HISTORY:
Surgical History:
____
____

Other Hospitalizations:____
____

Serious accidents, falls or injuries: ____

Any childhood accidents or physical traumas? ___________________________________
____

Do You Have Any Allergies? __________ To What?__________________________________

Present Weight: ______ One Year Ago: _______ 5 Years Ago: _______

GENERAL:
Do you have or have you had any of the following?

High Blood Pressure	____	Acne	____	Anorexia/Bulemia	____
High cholesterol	____	Eczema	____	Hepatitis Diabetes	____
Heart Problems	____	Skin Rashes	____	Headaches	____
Urinary tract infection	____	Skin Fungus	____	Asthma	____
Kidney Problems	____	Fatigue	____	Sinus Problem	____
Fainting Spells	____	Swollen Lymph	____	Lung problems	____
Frequent Cold or Flu	____	Cancer	____	Emotional Issues	____
Wounds heal slowly	____	Tried but can't loose weight ____			

How do you usually get sick or experience bodily distress? (digestive, respiratory, reproductive etc.) ____

How often does this happen? ____

FAMILY HISTORY: (List any medical conditions, problems in family members)

LIFESTYLE:
Tobacco Use: Yes No Past How Much and How Often: ____________________________
Alcohol Use: Yes No Past How Much and How Often: ____________________________
Caffeine Use: Yes No Past How Much and How Often: ____________________________
Other Drug Use: Yes No Past How Much and How Often: ____________________________

How frequently do you exercise? Daily ___ Weekly ___ Rarely ___
Type of exercise: ____

DIET:
Breakfast: ____
Lunch: ____
Dinner: ____
How many meals a week do you dine out? __________
How many times a week do you have:

Beef	___	White Rice	___	Soda Pop	___
Pork	___	White Bread	___	Coffee	___
Fish	___	Crackers	___	Black Tea	___
Chicken	___	Chips	___	Milk	___
Desserts	___	Ice Cream	___	Other Dairy	___
Canned Foods	___				

What would you say is the worst thing that you do on your diet? ________________________
Are you subject to binge eating? _____ Of what foods? ________________________________
What food do you find to be your weakness? ______________________________________
Do you eat breakfast every day? _________________ Eat regular meals? _______________

DIGESTION:
Appetite: good fair poor Digestion: good fair poor
Do you experience Bloating or Gas after meals? _____ Sour burps or heartburn? ________
Do you feel Sleepy or Tired after meals? _______ How often? Daily /Weekly /Occasional
Are you on a Restricted Diet? __________ Explain:____________________________________
When is the last time you took antibiotics? ____
Do you feel agitated or low functioning if you don't eat regularly? _________________________

ELIMINATION:
How often do you have a bowel movement? Daily __ __Times per Week Irregular __
Do you ever have hard stools? ___ Do you ever have loose stools? ___
Urination: normal ___ scanty ___ more than 5 times daily ___burning ___ strong odor ___
dark color ___ How many glasses of water do you drink daily? _____
Any history of bladder or kidney infections? _____ If so, at what age? ______________

WOMEN'S HEALTH:
Do you experience any of the following, past or present? PLEASE CIRCLE

Breast pain	Fibroids	Hot flashes
Irregular PAP	Vaginal dryness	Difficult menopause
Difficulty getting pregnant	Ovarian cysts	Pelvic pain
Endometriosis	Vaginal infection	Currently pregnant
STD's including HPV	Irregular menstrual cycles	No menstruation

MENSTRUAL CYCLE INFORMATION:
How many days do you menstruate? _________ Spotting before or after period: ___________
Clots? Yes no Clot Size____________ Number of clots____________
Color of menstrual blood: bright red maroon brown
Volume of menstrual blood ____________

MEN'S HEALTH:
Frequent Urination ____ Reproductive Issues ____
Prostate Problems ____ Painful Urination ____
Anything else? ____

STRESS LEVEL:
What would you rate your level of stress (0= no stress, 10 = maximum stress) _______________
What are the major sources of stress in your life? ____________________________________
Who provides you support in your life? ____
How many hours of sleep do you get on an average night? _________ Insomnia? _________
Do you usually wake up feeling tired _____ or rested ______?
Nerves: good ____ fair ____ poor ____
Anxiousness: often ____ sometimes ____ seldom ____
Depression: often ____ sometimes ____ seldom ____
Please explain your responses:____

EMOTIONAL AND SPIRITUAL:

If romantically involved, how is your relationship? ____________________________________

Were there any emotional traumas in your early or present life? Please explain briefly.
(ie. rape, great loss, suicide or death of a loved one, etc.) _________________________________
____

If possible, please explain what you feel to be your most experienced negative emotion:
____

When do you most often feel this emotion? ____

Where are you, when you feel this negative emotion? __________________________________

What is your opinion of yourself? ____

Have you ever been to counseling? _____ What was the outcome for you? ___________________

Briefly explain your relationship with each of your parents?

Mom: ____

Dad: ____

Rate Yourself:	None	Some	Lots
Faith			
Hope			
Charity			
Generosity			
Humor			
Fun			

WORK AND RECREATIONAL ACTIVITIES:

Occupation: ____

Do you enjoy your work? ____

Are you involved with activities outside of work? ____________________________________

If so, what type of activities? ____

Do you have any hobbies or interests? ____

Is there an unrealized longing in your life? ____ What is it? ___________________________