New Patient Intake Form

Please complete the following confidential questionnaire. **Today's Date:**

Patient Name:

Date of Birth: SSN ☐ Male ☐ Female

Address

City State Zip Code

Home Phone: Cell Phone:

Email Address: Marital Status: ☐ M ☐ S ☐ D ☐ W

Language: Race: Ethnicity:

Spouse/Significant Other's Name: # of Children & Ages:

How did you hear about our Clinic?:

Employer: Employer Addr:

Occupation: Work Phone:

Insurance Co.: Phone:

ID/Policy #: Group#:

Primary Insured /Card Holder: Date of Birth:

The Allergy & Environmental Treatment Center practice is located in the Vitality Center. It is not affiliated with any of the other separate and distinct businesses or individuals who also practice within the Vitality Center. Your signature on this form acknowledges your understanding of this fact .

What is the primary reason for your visit today?

How long have you had the symptoms /conditions?

Has this occurred before? ☐ Yes ☐ No

What exacerbates the condition?

Have you sought treatment elsewhere for your condition? If so, where and when did you do so?

How would you characterize your condition:

- ☐ Improving.
- ☐ Getting worse.
- ☐ Unchanged.

How is your condition interfering with daily living?

What do you believe caused this condition?

Please list the name, address, and phone number of your primary care provider:

Please list supplements, vitamins, minerals, homeopathic, and herbal remedies you use:

Name:		Quantity:		Dosage:	
Name:		Quantity:		Dosage:	
Name:		Quantity:		Dosage:	
Name:		Quantity:		Dosage:	

Please list prescriptions and non-prescription medications you currently take:

Name:		Quantity:		Dosage:	
Name:		Quantity:		Dosage:	
Name:		Quantity:		Dosage:	
Name:		Quantity:		Dosage:	

Please list any hospitalizations and surgeries:

Please list any known allergies:

Please indicate any of the following you use:

Do you smoke? Packs per day:: How many years?:

Alcohol: Drinks per: Quantity: Type:

Coffee or Black Tea: Cups per day:: ☐ Caffeinated ☐ Decaffeinated

Patient Name:

Please indicate any of the following you use: (Continued from previous page)

Soda: Drinks per day:: ☐ Diet ☐ Regular

Chocolate:: Pieces per day::

Exercise:

Type: Duration: Times per week: Intensity:

Type: Duration: Times per week: Intensity:

Type: Duration: Times per week: Intensity:

Type: Duration: Times per week: Intensity:

Comments:

Patient Name:

Condition Review: Place a check marke next to those symptoms that you now experience or have experienced in the past. Include all the complaints that are familiar to you. If there are one or more words in a line that describe your specific problem please circle them.

Condition	Current	Past
Weakness	☐	☐
Fatigue or lack of energy	☐	☐
Chills	☐	☐
Night sweats	☐	☐
Fever	☐	☐
Fainting	☐	☐
Weight gain	☐	☐
Weight loss	☐	☐
Heat intolerance	☐	☐
Cold intolerance	☐	☐
HEAD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Head injuries	☐	☐
Dizziness	☐	☐
Room spinning	☐	☐
EYES	☐	☐
Contact lenses	☐	☐
Glasses	☐	☐
Blurred vision	☐	☐
Dry, Burning or itching	☐	☐
Sensitive to light	☐	☐
Excessive watering	☐	☐
Glaucoma	☐	☐
Cataracts	☐	☐
Infections/Pink Eye	☐	☐
EARS	☐	☐
Ringing	☐	☐
Hearing loss	☐	☐
Discharge	☐	☐
Earaches	☐	☐
NOSE	☐	☐
Runny nose/Sinusitis	☐	☐
Loss of smell	☐	☐
Nose bleeds	☐	☐
Nasal pain	☐	☐

Condition	Current	Past
NOSE (Continued)	☐	☐
Deviated septum	☐	☐
THROAT / NECK	☐	☐
Hoarseness	☐	☐
Sore throat	☐	☐
Throat infections	☐	☐
Pain with swallowing	☐	☐
Swollen glands	☐	☐
Lumps or masses	☐	☐
Clear throat often	☐	☐
RESPIRATORY	☐	☐
Persistent cough	☐	☐
Shortness of breath	☐	☐
Phlegm	☐	☐
Bronchitis	☐	☐
Mucus or blood with cough	☐	☐
Exposure to irritants	☐	☐
BREASTS	☐	☐
Pain	☐	☐
Discharge	☐	☐
Lumps	☐	☐
Skin changes	☐	☐
Tenderness	☐	☐
HEART	☐	☐
Chest pain	☐	☐
Heart murmur	☐	☐
Heart attack	☐	☐
Rapid heartbeat	☐	☐
Heart palpitations	☐	☐
Blood clots	☐	☐
Varicose veins	☐	☐
Cold extremites	☐	☐
Discolored extremities	☐	☐
Tightness in chest	☐	☐
High blood pressure	☐	☐
Low blood pressure	☐	☐

Patient Name: _____

Condition	Current	Past
MOUTH	☐	☐
Excessive chapped lips	☐	☐
Loss of taste	☐	☐
Bleeding gums	☐	☐
Mouth sores	☐	☐
Bad breath	☐	☐
Sore/Red/Cracked Tongue	☐	☐
BLOOD	☐	☐
Bruising	☐	☐
Anemia	☐	☐
Bleeding	☐	☐
Sugar in blood	☐	☐
Swollen nodes	☐	☐
Painful nodes	☐	☐
MUSCULO-SKELETAL	☐	☐
Joint Pain	☐	☐
Joint stiffness	☐	☐
Muscle twitching	☐	☐
Muscle cramps	☐	☐
Muscle pain	☐	☐
Muscle weakness	☐	☐
GENITAL / URINARY	☐	☐
Urgency	☐	☐
Frequency	☐	☐
Incontinence	☐	☐
Painful urination	☐	☐
Bed wetting	☐	☐
Small stream	☐	☐
Cloudy urine	☐	☐
Straining	☐	☐
Discharge	☐	☐
Burning/Itching genitals	☐	☐
Back pain	☐	☐
Low sexual desire	☐	☐
Excessive sexual desire	☐	☐
Impotence	☐	☐
Sexually transmitted disease	☐	☐

Condition	Current	Past
GASTRO-INTESTINAL	☐	☐
Abdominal pain	☐	☐
Indigestion	☐	☐
Bloating	☐	☐
Belching	☐	☐
Constipation	☐	☐
Gas	☐	☐
Diarrhea	☐	☐
Irregular bowel	☐	☐
Hemorrhoids	☐	☐
Loss of appetite	☐	☐
Food intolerance	☐	☐
Nausea and/or vomiting	☐	☐
Metallic or bitter taste in mouth	☐	☐
Acid reflux	☐	☐
Heartburn	☐	☐
Bloody stools	☐	☐
SKIN	☐	☐
Cust heal slowly	☐	☐
Acne	☐	☐
Dryness or roughness	☐	☐
Rashes	☐	☐
Skin Ulcers or sores	☐	☐
Hives	☐	☐
Moles, warts, or skin tags	☐	☐
Hair loss or thinning	☐	☐
NEUROLOGICAL	☐	☐
Loss of memory	☐	☐
Loss of sensation	☐	☐
Numbness	☐	☐
Tingling	☐	☐
Seizures	☐	☐
Dizziness	☐	☐
Vertigo	☐	☐
Hand trembling	☐	☐
Weak grip	☐	☐
Slurred or difficult speech	☐	☐

Patient Name:

Condition	Current	Past
NEUROLOGICAL (Continued)	☐	☐
Coordination	☐	☐
PSYCHIATRIC	☐	☐
Anxiety	☐	☐
Depression	☐	☐
Irritability	☐	☐
Extreme worry	☐	☐
Hallucinations	☐	☐
Suicidal thoughts	☐	☐
Sexual problems	☐	☐
Memory loss	☐	☐
Insecurity	☐	☐
Alcoholism	☐	☐
Drug addiction	☐	☐
Drug dependency	☐	☐
Hyperventilation	☐	☐
Insomnia	☐	☐
Panic attacks	☐	☐

Condition	Current	Past
FEMALES ONLY	☐	☐
Irregular periods	☐	☐
Heavy periods	☐	☐
Pain prior to or with periods	☐	☐
Mood swings around periods	☐	☐
Pregnant	☐	☐
Birth Control	☐	☐
Painful intercourse	☐	☐
Hot flashes	☐	☐
Spotting between periods	☐	☐
Vaginal dryness	☐	☐
Infertility	☐	☐
Uterine fibroids	☐	☐
Hormone Replace'nt Therapy	☐	☐
	☐	☐
	☐	☐
	☐	☐
	☐	☐

IMMUNIZATIONS: Please check any of the following immunizations that you have had:

- ☐ DPT
- ☐ Mumps
- ☐ Smallpox
- ☐ Polio
- ☐ MMR
- ☐ Tetanus
- ☐ Influenza/Flu
- ☐ Pneumococcal
- ☐ Typhoid
- ☐ Measles

BLOOD TYPE:

Patient Name:

PAST MEDICAL HISTORY: Please check any of the following conditions that you have had:

- ☐ Heart trouble
- ☐ Cancer
- ☐ Tumor
- ☐ Allergies
- ☐ Blood Disease
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Mumps
- ☐ Polio
- ☐ Measles
- ☐ Chicken Pox
- ☐ Epilepsy
- ☐ Paralysis
- ☐ Mental Illness
- ☐ Jaundice
- ☐ Rheumatic Fever
- ☐ Ulcers
- ☐ Gout
- ☐ Prostate Problems
- ☐ Syphilis
- ☐ Gonorrhea
- ☐ Diabetes
- ☐ Bladder Trouble
- ☐ Kidney Stones
- ☐ Kidney Infections
- ☐ Urinary Tract Infections
- ☐ Phlebitis
- ☐ Varicose Veins
- ☐ Parasites
- ☐ Hepatitis
- ☐ Liver Trouble
- ☐ Gall Stones
- ☐ Angina

FAMILY HISTORY

Relative	Age if Living	State of Health	Major Illnesses	Age at Death	Cause of Death
Father					
Mother					
Brother(s)					
Sister(s)					
Maternal Grandfather					
Maternal Grandmother					
Paternal Grandfather					
Paternal Grandmother					

Please provide any other information we should know concerning your healthcare. (Past/Present)

Patient Signature: _____ Date

Legal Guardian _____ Date

Doctore Signature: _____ Date

Subjective Stress Assessment

Click on the box that corresponds most closely to how you currently rate yourself on the following scale.

	5	4	3	2	1	0	1	2	3	4	5	
Relaxed	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Tense
Calm	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Anxious
Worry Free	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Worry Excessively
Happy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Depressed
High Energy	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Low Energy
Sleep Good	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Sleep Poor
Unhurried	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Hurried/ Pressured
Carefree	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Over Committed
Daily Relaxation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	No Daily Relaxation
Take Time for Recreation	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	No time for hobbies/relax
Enjoy Job	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Detest Job
Satisfying Life	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Not fulfilled/Frustrated
Achieve Personal Goals	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Not Achieving Goals
Feel Loved	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Angry or Resentful
Live in quiet surroundings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Live in noisy environment
Ordered Surroundings	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	☐	Chaotic Surroundings

Patient Name:

Print Form