New Client Health Intake Form

Today's Date: ___________________________

First & Last Name	*Date of Birth*	*Age*	*Sex*
			☐ Female ☐ Male
Address	***City***	***ST***	***Zip***
Home Telephone	***Cell Phone***		

1. Please feel free to share any recent events you feel I should know about any physical, mental or emotional issues you have experienced.

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2. Please describe your goals for this assessment (*ie:* relief of pain, eliminate fatigue, prevention, increase energy, correction of current issues…)

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3. What methods, therapies, or other modalities have you tried?

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Name: ____ Date: ____________________

PAST MEDICAL HISTORY	DATES	ADDITIONAL NOTES
Anemia or history of blood transfusion		
Autoimmune disorder *(SLE, Graves,etc.)*		
Cancer		
Candida - Yeast infection -Thrush		
CFS or Fibromyalgia		
Diabetes		
Fatigue *(describe; under what conditions)*		
Fever or frequent infections		
Generalized weakness		
Heart Disease		
Hepatitis		
High Blood Pressure		
HIV / AIDS		
Hormone imbalance		
Pain / aching		
Where:		
Describe *(sharp, dull, etc.)*		
How long:		
Under what conditions:		
Rheumatic Fever		
Seizures		
Swollen glands		
Thyroid disease		
Other not listed		

FAMILY MEDICAL HISTORY	WHICH FAMILY MEMBER(s)	ADDITIONAL NOTES
Food sensitivities		
Autoimmune disorders		
Anxiety/Depression		
Strokes, TIA's		
Cancer		
Diabetes		
Heart attack or heart disease		
Hepatitis or Liver disease		
High Blood Pressure		
HIV/AIDS		
Obesity		
Seizures		
Thyroid disease		
Dementia/Alzheimer's		
High Cholesterol		

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Name: ____ Date: ____________________

GENERAL					
Birth Trauma	Yes	No	Chills	Yes	No
Cold Feet	Yes	No	Dizziness *(vertigo)*	Yes	No
Cold Hands	Yes	No	Fatigue	Yes	No
Cravings	Yes	No	Fevers	Yes	No
If yes, for what? *(i.e., sweet, salty, etc.)*	Yes	No	Night Sweats	Yes	No
			Poor heat / cold tolerance	Yes	No
Excess sleep	Yes	No	Rarely sweat	Yes	No
Excessive thirst *(mouth feels like cotton)*	Yes	No	Sudden energy drop	Yes	No
			Time of day:		
Emotional or Stress Eater?	Yes	No	Sweat easily	Yes	No
Insomnia	Yes	No	Tired upon awakening in morning *(feel like you haven't slept)*	Yes	No
Low blood sugar	Yes	No			
Peculiar tastes/smells	Yes	No	Sudden weight gain or loss *(Circle one)*	Yes	No
Poor Appetite	Yes	No			
Poor / restless sleep	Yes	No	How many pounds:		
Other:					

SKIN, HAIR & NAILS					
Acne / pimples	Yes	No	Bruise easily	Yes	No
Athlete's foot	Yes	No	Cuts heal slowly	Yes	No
Change in hair/skin texture	Yes	No	Dandruff	Yes	No
Crawling sensation	Yes	No	Eczema	Yes	No
Dry skin	Yes	No	Nail fungus	Yes	No
Hives	Yes	No	Peeling or cracking skin on feet	Yes	No
Itching	Yes	No	Psoriasis	Yes	No
Oily skin	Yes	No	Split or ridged nails	Yes	No
Rashes	Yes	No	Sweating	Yes	No
Pigmentation / brown spots	Yes	No	White spots on nails	Yes	No
Brittle nails	Yes	No	Other		

EYES, EARS, NOSE & THROAT					
Blindness or decreased vision	Yes	No	Itching in ear canal	Yes	No
Cataracts	Yes	No	Itching/redness wearing earrings	Yes	No
Color blindness	Yes	No	Ringing or buzzing in ears	Yes	No
Blurred / tunnel vision	Yes	No	Cold sores	Yes	No
Dark circles under eyes	Yes	No	Excessive mucous	Yes	No
Floaters in eyes	Yes	No	Hay fever	Yes	No
Glaucoma	Yes	No	Nasal polyps	Yes	No
Gritty feeling in eyes/dry eyes	Yes	No	Nose bleeds	Yes	No
Halos around lights	Yes	No	Runny nose	Yes	No
Sensitive to sunlight or strong light	Yes	No	Sinus problems	Yes	No
			Sneezing attacks	Yes	No
Watery, itchy eyes	Yes	No	Stuffy nose	Yes	No
Deafness	Yes	No	Bleeding gums	Yes	No
Drainage from ears	Yes	No	Canker sores	Yes	No
Earaches, ear infections	Yes	No	Chronic coughing	Yes	No

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EYES, EARS, NOSE & THROAT *(continued)*					
Frequent sore throats	Yes	No	Discoloration of gums	Yes	No
Enlarged lymph nodes	Yes	No	Swallowing difficulty	Yes	No
Grinding teeth	Yes	No	Tonsillitis	Yes	No
Hoarseness	Yes	No	Other		

CARDIOVASCULAR					
Abnormal electrocardiogram *(EKG)*	Yes	No	Heart surgery	Yes	No
Angina *(heart / chest pain)*	Yes	No	High blood pressure	Yes	No
Awaken from sleep with shortness of breath	Yes	No	High cholesterol	Yes	No
Blood clots	Yes	No	Irregular/skipped heartbeats or palpitations	Yes	No
Difficulty breathing	Yes	No	Low blood pressure	Yes	No
Enlarged heart	Yes	No	Numbness of hands / feet	Yes	No
Fainting	Yes	No	Pacemaker	Yes	No
Heart attack	Yes	No	Phlebitis	Yes	No
Heart murmur	Yes	No	Rapid heartbeats	Yes	No
Other					

RESPIRATORY					
Allergies	Yes	No	Sleep apnea	Yes	No
Asthma	Yes	No	Tuberculosis	Yes	No
Cough	Yes	No	Abnormal chest x-ray	Yes	No
Difficulty breathing	Yes	No	History of Bronchitis	Yes	No
Low exercise tolerance	Yes	No	Chest congestion	Yes	No
Pain with deep breathing	Yes	No	COPD or Emphysema	Yes	No
Shortness of breath with activity *(or at rest)*	Yes	No	History of Pneumonia	Yes	No
			Use inhalers or wheezing	Yes	No
Other					

GASTROINTESTINAL					
Abdominal pain/cramps	Yes	No	Diarrhea, persistent	Yes	No
Alternating constipation & diarrhea	Yes	No	Diverticulosis or Diverticulitis	Yes	No
Bad breath or bad taste in your mouth	Yes	No	Frequent belching/flatulence or gas	Yes	No
Black or bloody stools	Yes	No	Gallbladder attacks or stones	Yes	No
Bloated feeling/abdominal distention	Yes	No	Hiatal hernia	Yes	No
			Heartburn or GERD	Yes	No
Bowel habit changes	Yes	No	Hemorrhoids	Yes	No
Irritable bowel syndrome (IBS)	Yes	No	Nausea	Yes	No
Colon polyps	Yes	No	Nervous stomach	Yes	No
Constipation	Yes	No	Rectal bleeding	Yes	No
Crohn's or Ulcerative colitis	Yes	No	Rectal itch or pain	Yes	No
Ulcers	Yes	No	Bowel movements *(how often per day)*	Yes	No
Helicobacter pylori	Yes	No			
Feel sick 30 mins after eating	Yes	No	Other		

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GENITO-URINARY						
Frequent urination	Yes	No		Urgency to urinate	Yes	No
Interstitial cystitis	Yes	No		Gout	Yes	No
Kidney pain *(mid-back)*	Yes	No		H/O kidney infections	Yes	No
Pain on urination without infection	Yes	No		Kidney stones	Yes	No
Problem passing urine	Yes	No		Sexually transmitted disease	Yes	No
Trouble holding urine/incontinence	Yes	No		Wake up to urinate *(how often per night?)*		
Other						

PREGNANCY & GYNECOLOGY						
Age of first menses (period)				Endometriosis	Yes	No
Flow: Heavy / Light / Clots (circle one)				Fibroid Uterus	Yes	No
Period duration (How many Days?)				Hot flashes	Yes	No
Last mammogram				Infertility, difficulty getting pregnant	Yes	No
Last Pap Smear				Irregular periods	Yes	No
Abnormal	Yes	No		Painful Periods (Cramping)	Yes	No
Birth control	Yes	No		Pain with intercourse	Yes	No
Type:				PMS *(moody, cravings, breast tenderness, bloating)*	Yes	No
Hormone replacement	Yes	No				
Which:				Ovarian cysts or PCOS	Yes	No
Menopause (date):				Vaginal discharge or itching	Yes	No
Breast lumps	Yes	No		Vaginal dryness	Yes	No
Low sex drive	Yes	No		History of STD(s)	Yes	No
Other						

MALE REPRODUCTIVE						
Enlarged prostate gland	Yes	No		Premature ejaculation	Yes	No
Erection problem	Yes	No		Sex drive decreased	Yes	No
Lump in testicles	Yes	No		History of STD(s)	Yes	No
Penis discharge	Yes	No		Other		

MUSCOLOSKELETAL						
Pain	Yes	No		Osteoporosis or Osteopenia	Yes	No
Where:				Tightness between shoulder blades	Yes	No
Stiffness	Yes	No		Rheumatoid Arthritis	Yes	No
Where:				Joint swelling	Yes	No
Swelling	Yes	No		Muscle weakness, numbness or tingling	Yes	No
Where:						
Enlarged knuckles or bumps on joints	Yes	No		Damp weather causes aching	Yes	No
Where:				Pain or popping in jaw	Yes	No
Head injury	Yes	No		Loss of bowel or bladder control	Yes	No
Low back stiffness	Yes	No		Sciatica	Yes	No
Loss of consciousness	Yes	No		Other		

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NEURO-PSYCHOLOGICAL					
Anger, irritability	Yes	No	Alzheimer's or Parkinson's	Yes	No
Anxiety, fear, nervousness *(panic attacks)*	Yes	No	Areas of numbness or tingling Where:	Yes	No
Concussions or blunt head trauma	Yes	No	Mood swings	Yes	No
Confusion	Yes	No	Slurred speech	Yes	No
Depression	Yes	No	Stuttering, stammering	Yes	No
Hx of Drug or Alcohol addiction	Yes	No	Have you taken meds for anxiety or depression	Yes	No
Easily stressed or overwhelmed	Yes	No			
Fatigue, sluggishness	Yes	No	Phobias, irrational fears	Yes	No
Headaches *(Stress, Tension, Cluster or Migraines)* When:			Poor coordination	Yes	No
			Strokes (mini-stroke or TIA)	Yes	No
Where *(front, back, sides)*			Poor memory, forgetfulness	Yes	No
History of Seizures	Yes	No	Restlessness	Yes	No
Hyperactivity or ADD	Yes	No	Tremors (shaking, twitching)	Yes	No
Insomnia	Yes	No	Brain Fog or Poor Concentration	Yes	No
Worry frequently	Yes	No	Other		

ELECTROMAGNETIC RADIATON					
Frequent x-rays	Yes	No	Work with computers	Yes	No
Live under or near power lines	Yes	No	Other radiation exposure	Yes	No
Use a waterbed or electric blanket	Yes	No	Describe:		

PERSONAL HABITS						
Smoke	Yes No	Packs/day?	Hours of sleep nightly:			
Quit Smoking?	How long ago?		How often do you get up at night:			
Chew tobacco	Yes No	How much/day?	Sleep aids:			
Coffee	Yes No	Cups/day?	Hours worked per week:			
Tea	Yes No	Cups/day?	What you do to relax:			
Carbonated beverages	Yes No	How many/day?	Do you pray?	Yes	No
			Do you Meditate?	Yes	No
Drink alcohol	Yes No	If yes: (check one) ☐ Daily ☐ Frequently ☐ Rarely ☐Occasionally	Practice Yoga?	Yes	No
			Other?		
Get regular exercise?	Yes No				

KNOWN SENSITIVITIES					
Aspirin	Yes	No	Mold	Yes	No
Carpet / furniture / cabinets	Yes	No	Penicillin	Yes	No
Chemicals	Yes	No	Pet Dander	Yes	No
Cold Weather	Yes	No	Ragweed	Yes	No
Cologne / scented products	Yes	No	Pesticides, fumigation	Yes	No
Dust	Yes	No	Pollen	Yes	No
Fabric	Yes	No	Smoke	Yes	No
Metals	Yes	No	Sulfa drugs (antibiotics)	Yes	No

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KNOWN SENSITIVITIES *(continued)*			
Foods	Yes No	Other allergies	Yes No
List:		List:	

DENTAL			
Metal amalgam fillings	Yes No	Sensitive teeth	Yes No
If removed, when:		Dental problems	Yes No
Bridges in mouth	Yes No	Other	
Crown / caps	Yes No		

WEIGHT			
Present:		Desired:	

HERBS, MEDICATIONS, VITAMINS & SUPPLEMENTS

Please list what you take daily

Name	Strength	How Taken	Total Pills/day	Who Prescribed

ALLERGIES AND INTOLERANCES

There may be drugs or herbs that you cannot use because of intolerance or side effects.
Please list them:

What you cannot take	What happens when you take it

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