NEW PATIENT INTAKE

Patient Information:

Name: _____ Date:_____

Address: _____

Preferred Phone: (_____) _____ Alternate Phone:(_____)_____

Leaving Voice Message OK: Y N Preferred method of contact:_____

E-mail address: _____

Age:_____ Date of Birth:_____/_____/_____

What is your birth sex: female _____ male _____ other_____

What gender do you identify as: female _____ male _____ other _____

What pronouns do you use? female _____ male _____ other_____

Married____ Partnered___ Separated___ Divorced___ Widowed____ Single____

Housing: Spouse/Partner _____Parents _____ Children_____ Friend/Roommate _____ Alone _____

Occupation:_____ Hours per week:_____ Retired:_____

Employer:_____

Emergency contact: _____

Relationship: _____ Phone: (_____)_____

Address: _____

How did you hear about my clinic? _____

PLEASE FILL OUT BOTH SIDES OF EACH PAGE

Successful health care and preventive medicine are only possible when the physician has an understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting my understanding of your health. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Are you currently receiving healthcare? Y N
If yes, where and from whom:_____
If no, when, where, and why did you last receive health care?

_____

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

1) 4)
2) 5)
3) 6)

ALLERGIES

Are you hypersensitive or allergic to...

Any drugs?_____

Any foods?_____

Any environmentals or chemicals?_____

MEDICATIONS, VITAMINS, & SUPPLEMENTS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you are ***currently*** taking? **Please list doses and frequency** (eg Tylenol 325 mg, 3x/day)

1) _____ 6)_____

2) _____ 7)_____

3) _____ 8)_____

4) _____ 9)_____

5) _____ 10)_____

Please list any medications you have taken in the past:_____

Have your medications or supplements ever caused you unusual side effects or problems?
Describe:_____

MEDICAL HISTORY

Hospitalization, Surgery, Imaging:
Please list all hospitalizations, surgeries, dental work, X-Rays, CAT Scans, ultrasounds, EEG, EKG's, Mammograms, bone scans, DEXA, colonoscopy, or other tests.

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

_____ year: _____ _____ year: _____

Any Major events or health conditions that have occurred during your lifespan:
Please list:

REVIEW OF SYSTEMS

PLEASE CIRCLE: Y= Current condition N= Never had P= Past condition

Current Height: Weight:	Recent change in weight? Y N How much?
Weight 1 year ago: lbs	Maximum Weight: When:

Skin

Rashes	Y	N	P	Acne, boils, sores	Y	N	P
Itching	Y	N	P	Hair loss	Y	N	P
Color change	Y	N	P	Lumps, bumps, growths	Y	N	P
Skin cancer	Y	N	P	Night sweats	Y	N	P
Eczema/hives	Y	N	P	Excessive sweating	Y	N	P

Head

Headaches	Y	N	P	Lightheadedness	Y	N	P
Migraines	Y	N	P	Head injury	Y	N	P

Eyes

Floaters/spots in vision	Y	N	P	Blurriness	Y	N	P
Impaired vision	Y	N	P	Double vision	Y	N	P
Corrective lenses	Y	N	P	Excessive tearing or dryness	Y	N	P
Glaucoma or cataracts	Y	N	P	Eye Pain/Strain	Y	N	P

Ears

Hearing loss	Y	N	P	Ringing	Y	N	P
Earache/pain or Itching	Y	N	P	Frequent ear infections	Y	N	P

Nose and Sinuses

Frequent Colds	Y	N	P	Nose Bleeds	Y	N	P
Hay fever/Seasonal allergies	Y	N	P	Stuffiness or discharge	Y	N	P
Loss of smell	Y	N	P	Sinus pain/infection	Y	N	P

Mouth and Throat

Sore tongue/lips	Y	N	P	Frequent sore throat	Y	N	P
Mouth sores	Y	N	P	Hoarseness	Y	N	P
Dry mouth	Y	N	P	TMJ Disease/teeth grinding	Y	N	P
Gum problems	Y	N	P	Dental cavities	Y	N	P

Neck

Swollen glands	Y	N	P	Goiter	Y	N	P
Lumps	Y	N	P	Pain or stiffness	Y	N	P

Respiratory

Cough	Y	N	P	Emphysema	Y	N	P
Asthma or wheezing	Y	N	P	Chronic bronchitis	Y	N	P
Sputum/mucous	Y	N	P	Pneumonia	Y	N	P
Spitting up blood	Y	N	P	Difficulty breathing	Y	N	P
Tuberculosis	Y	N	P	Pain with breathing	Y	N	P

Cardiovascular

Heart disease	Y	N	P	Chest pain	Y	N	P
Murmurs	Y	N	P	High/Low blood pressure	Y	N	P
Rheumatic fever	Y	N	P	Palpitations/fluttering	Y	N	P
Ankle swelling	Y	N	P	High cholesterol	Y	N	P

Blood / Peripheral Vascular

Anemia	Y	N	P	Easy bleeding/bruising	Y	N	P
Blood clots	Y	N	P	Cold hands/feet	Y	N	P
Varicose veins	Y	N	P	Past transfusions	Y	N	P

Immune

Chronic infections	Y	N	P	Autoimmune disease	Y	N	P
Chronic fatigue	Y	N	P	Fever	Y	N	P
Slow wound healing	Y	N	P	Chills	Y	N	P

Gastrointestinal

Difficulty swallowing	Y	N	P	Hemorrhoids or blood in toilet	Y	N	P
Heartburn/Reflux	Y	N	P	Constipation	Y	N	P
Belching or passing gas	Y	N	P	Diarrhea	Y	N	P
Ulcer	Y	N	P	Number of BM's per day:			
Abdominal pain	Y	N	P	Change in bowel habits	Y	N	P
Abdominal cramps	Y	N	P	Dark/black stools	Y	N	P
Nausea/vomiting	Y	N	P	Light/white stools	Y	N	P
Change in appetite	Y	N	P	Liver disease/hepatitis	Y	N	P
Jaundice (yellow skin)	Y	N	P	Gallbladder disease	Y	N	P

Urinary

Pain with urination	Y	N	P	Kidney stones	Y	N	P
Increased frequency (day/night)	Y	N	P	Frequent urinary infections	Y	N	P
Urgency	Y	N	P	Cloudy urine	Y	N	P
Inability to hold urine	Y	N	P	Blood in urine	Y	N	P
Hesitancy or dribbling	Y	N	P	Change in force of stream	Y	N	P

General Reproductive

Are you sexually active	Y	N	P	Chlamydia or gonorrhea	Y	N	P
Type of Contraception:				Genital warts	Y	N	P
Sleep w/ men, women, both?				Herpes	Y	N	P
Low sex drive	Y	N	P	Other sexually transmitted disease	Y	N	P
Have you been recently tested for sexually transmitted diseases?							

Male Reproductive

Hernia	Y	N	P	Sores on penis or testicles	Y	N	P
Testicular pain	Y	N	P	Premature ejaculation	Y	N	P
Lump in testicles	Y	N	P	Erectile dysfunction	Y	N	P
Prostate disease	Y	N	P	Impotence	Y	N	P
Prostate removed	Y	N	P	Discharge	Y	N	P
Fertility issues	Y	N	P	Low sperm count	Y	N	P

Female Reproduction

Age of first menses:				Age of last menses (if menopausal):			
Date of last menses:				Date of last pap exam:			
Duration of bleeding: days				Abnormal PAP ever?	Y	N	P
Length of cycle: days (usu 25-35)				Cervical dysplasia	Y	N	P
Cycles regular	Y	N	P	Vaginal discharge	Y	N	P
Spotting between cycles	Y	N	P	Vaginal itching, pain, burning	Y	N	P
Pain with menses	Y	N	P	Vaginal sores or lumps	Y	N	P
Clotting with menses	Y	N	P	Pain with intercourse	Y	N	P
Heavy flow with menses	Y	N	P	Ovarian cysts/fibroids	Y	N	P
PMS	Y	N	P	Difficulty conceiving	Y	N	P
Menopausal symptoms	Y	N	P	Number of pregnancies:			
Endometriosis	Y	N	P	Number of live births:			
PCOS	Y	N	P	Number of abortions:			
				Number of miscarriages:			

Breasts/chest:

Regular self breast exams	Y	N	P	Breast lumps	Y	N	P
Breast pain/tenderness	Y	N	P	Nipple discharge	Y	N	P

Neurologic

Fainting	Y	N	P	Vertigo or Dizziness	Y	N	P
Paralysis	Y	N	P	Seizures	Y	N	P
Tremors or twitches	Y	N	P	Muscle Weakness	Y	N	P
Loss of Memory	Y	N	P	Numbness/tingling	Y	N	P
Loss of Balance	Y	N	P	Nerve/Sciatic Pain	Y	N	P

Endocrine

Diabetes/High blood sugar	Y	N	P	Excessive thirst or hunger	Y	N	P
Hypoglycemia/Low blood sugar	Y	N	P	Fatigue	Y	N	P
Hypo or hyper thyroid	Y	N	P	Heat or cold intolerance	Y	N	P

Mental/Emotional

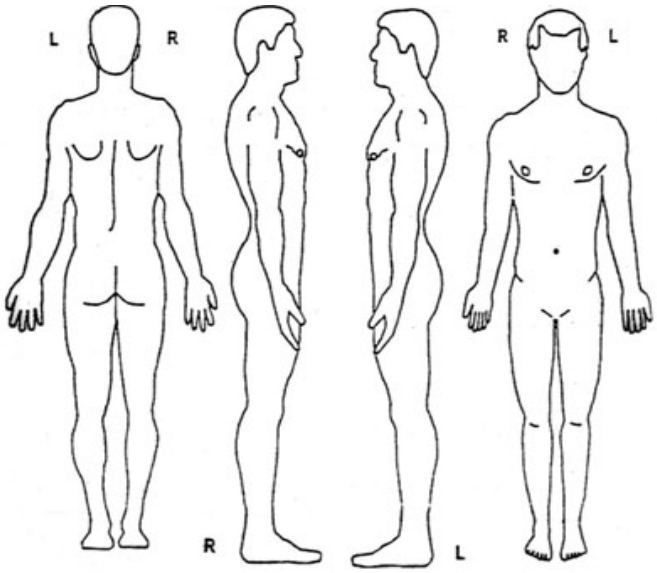
Depression	Y	N	P	Anxiety or nervousness	Y	N	P
Mood Swings	Y	N	P	Tension	Y	N	P
Considered/Attempted suicide	Y	N	P	Poor concentration	Y	N	P
Any major traumas	Y	N	P	History of counseling?	Y	N	P
Have a history of abuse	Y	N	P	Eating Disorder	Y	N	P

Sleep

Insomnia	Y	N	P	Difficulty falling asleep?	Y	N	P
Wake rested?	Y	N	P	Difficulty staying asleep?	Y	N	P
Number of hours you sleep per night?				Do you have low energy during the day?	Y	N	P

Musculoskeletal

Arthritis	Y	N	P	Gout	Y	N	P
Osteopenia/osteoporosis	Y	N	P	Joint pain/stiffness	Y	N	P
Broken bones	Y	N	P	Muscle spasms or cramps	Y	N	P
Heaviness of the limbs	Y	N	P	Muscle weakness	Y	N	P



Please place a mark on the image where you have muscle or joint pain.

Use an X to describe sharp/stabbing pain

Use a P to describe pins and needles

Use a D to describe dull/aching pain

Use an N to describe numbness

HABITS & LIFESTYLE

PLEASE CIRCLE: Y= Current condition N= Never had P= Past condition

Do you exercise?	Y	N	P	Do you use tobacco	Y	N	P
How often do you exercise?				Smoked for how many years?			
How much do you watch TV daily?				How many packs per day?			
Do you enjoy your work?	Y	N	P	Do you drink alcohol?	Y	N	P
Do you take vacations?	Y	N	P	How much alcohol per week?			
Do you have a spiritual practice?	Y	N	P	Do you use recreational drugs?	Y	N	P
Do you eat 3 meals a day?	Y	N	P	Treated for dependency?	Y	N	P
Do you eat out often?	Y	N	P	Do you drink coffee?	Y	N	P
Do you eat protein at each meal?	Y	N	P	Do you drink soda?	Y	N	P
Do you think you are under or over weight?	Y	N	P	How much water do you drink per day?			

Do you eat a special diet?
What is a typical breakfast for you?
What is a typical lunch for you?
What is a typical dinner for you?
What snacks do you eat?

What expectations do you have for this visit?

What long-term expectations do you have for your health?

What is your level of commitment to address underlying causes of your signs and symptoms that relate to your lifestyle (diet, exercise, stress reduction, etc)? (Rated 0 to 10; 10 being 100% committed)

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

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits?

Is there anything else you would like me to know?

FAMILY HISTORY

Do you have a family history of any of the following? (**Please circle**)

Cancer	Epilepsy	Asthma
Diabetes	Arthritis	Anemia
Heart Disease/Heart attack	Glaucoma	Autoimmune disease
High Blood Pressure	Kidney Disease	Tuberculosis
High Cholesterol	Stroke	Mental Illness

Family Member	**Age**	**Major Health Issues**	**If applicable, cause & age of death**
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandfather			
Paternal Grandmother			
Other			

Thank you for taking the time to fill out this questionnaire. I look forward to working with you!

STATEMENT OF FINANCIAL RESPONSIBILITY

I understand and agree to the following general responsibilities:

• I am responsible as the patient or patient's guarantor for full payment of services rendered at the time of service, including all supplements, herbal formulas, supplies, lab work and tests, and physician ordered add-on lab work and tests, as well as any additional expenses incurred in connection to my healthcare, such as: postage and delivery, shipping and handling, and phone calls to the provider or clinic wherein medical advice is provided.

• I acknowledge that I am financially responsible for all charges. If it becomes necessary to effect collections of any amounts owed on this or subsequent visits, I agree to pay for all costs and expenses, including reasonable attorney fees.

• I hereby authorize Cora Forsten ND, Lac MSOM and Cora Forsten Wellness to release information necessary to secure payment.

• I understand that I will be charged the cost of the visit for any missed appointments with less than 24 hour notice of scheduled appointment. Leeway will be given for emergency situations.

• Fees and rates are adjusted periodically and therefore may increase during the term of our engagement. While we will do our best to avoid unknown adjustments, on occasion such changes may occur without written notice.

• I have fully read and understand the above agreements and authorizations.

_____ _____

Patient (18 years or older) or Parent, Guardian Signature Date

_____ _____

Please Print Name Date