PATIENT INTAKE QUESTIONNAIRE

All questions contained in this questionnaire are strictly confidential and will become part of your medical record.

Name *(Last, First, M.I.):*		**Today's Date**	
Address *(Street.):*		**Date of Birth**	
(City, State, Zip.):		**Race/Ethnicity**	
Email		**Gender**	
Phone	H: M:	W:	
Marital status:	☐ Single ☐ Partnered ☐ Married ☐ Separated ☐ Divorced ☐ Widowed		
Current Weight		**Current Height**	
How did you hear about me?			
Best time to Contact You?	◯ **Morning** ◯ **Afternoon** ◯ **Evening**		

CHIEF COMPLAINT

What is the primary health concern or goal that brings you to the clinic?

Brief History of Chief Complaint (when it started, what makes it better/worse, severity, etc)

List other health issues you hope to address

PERSONAL HEALTH HISTORY				
List any medical issues that doctors have diagnosed				
Surgeries				
Year	Reason	Hospital		
Previous hospitalizations				
Year	Reason	Hospital		
Have you ever had a blood transfusion?			☐ Yes	☐ No

List your prescribed drugs and over-the-counter drugs, such as vitamins and inhalers		
Name the Drug	Strength	Frequency Taken
Allergies		
Name the Drug	Reaction You Had	
Any Other Allergies		

HEALTH HABITS AND PERSONAL SAFETY

ALL QUESTIONS CONTAINED IN THIS QUESTIONNAIRE ARE OPTIONAL AND WILL BE KEPT STRICTLY CONFIDENTIAL.

Exercise	Describe exercise activities: the frequency, intensity, time and type of activity. For example (twice weekly beginner 1 hour yoga classes)				
Activities	Describe your interests, hobbies, spiritual practices, things you do to relax				
Diet	Are you dieting?	☐	Yes	☐	No
	If yes, are you on a physician prescribed medical diet?	☐	Yes	☐	No
	# of meals you eat in an average day?				
	What Have you eaten in the last 24 hours?				
	If the above dietary recall is atypical for you, describe a typical day here.				
	List your favorite healthy foods				
Caffeine	☐ None	☐ Coffee	☐ Tea	☐ Cola	
	Number of cups/cans per day?				
Alcohol	Do you drink alcohol?	☐	Yes	☐	No
	If yes, what kind?				
	How many drinks per week?				
	Are you concerned about the amount you drink?	☐	Yes	☐	No
	Have you considered stopping?	☐	Yes	☐	No
	Have you ever experienced blackouts?	☐	Yes	☐	No
	Are you prone to "binge" drinking?	☐	Yes	☐	No
	Do you drive after drinking?	☐	Yes	☐	No
Tobacco	Do you use tobacco?	☐	Yes	☐	No
	☐ Cigarettes – pks./day:	☐ Chew - #/day:	☐ Pipe - #/day:	☐ Cigars - #/day:	
	☐ # of years:	☐ Or year quit:			

Drugs	Do you currently use recreational or street drugs?	☐	Yes	☐	No
	Have you ever given yourself street drugs with a needle?	☐	Yes	☐	No
Sex	Are you sexually active?	☐	Yes	☐	No
	If yes, are you trying for a pregnancy?	☐	Yes	☐	No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?	☐	Yes	☐	No
Personal Safety	Do you live alone	☐	Yes	☐	No
	Do you have traction stickers or bathtub mat?	☐	Yes	☐	No
	Do you have a fire extinguisher?	☐	Yes	☐	No
	Do you have frequent falls?	☐	Yes	☐	No
	Do you have vision or hearing loss?	☐	Yes	☐	No
	Do you have an Advance Directive or Living Will?	☐	Yes	☐	No
	Do you wear a seatbelt?	☐	Yes	☐	No

FAMILY HEALTH HISTORY

FOR DECEASED RELATIVES MARK A LETTER "D" AND THEIR AGE AT DEATH, SPECIFY CAUSE OF DEATH IF KNOWN

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			**Children**	☐ M ☐ F	
Mother				☐ M ☐ F	
Sibling(s)	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F			☐ M ☐ F	
	☐ M ☐ F		**Grandmother** *Maternal*		
	☐ M ☐ F				
	☐ M ☐ F		**Grandfather** *Maternal*		
	☐ M ☐ F				
	☐ M ☐ F		**Grandmother** *Paternal*		
	☐ M ☐ F				
	☐ M ☐ F		**Grandfather** *Paternal*		
	☐ M ☐ F				

WOMEN ONLY							
Age at onset of menstruation:							
Date of last menstruation:							
Period every how many days?							
Heavy periods, irregularity, spotting, pain, or discharge?					☐	Yes	☐ No
Number of pregnancies:		Number of live births:					
Are you pregnant or breastfeeding?					☐	Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?					☐	Yes	☐ No
Any urinary tract, bladder, or kidney infections within the last year?					☐	Yes	☐ No
Any blood in your urine?					☐	Yes	☐ No
Any problems with control of urination?					☐	Yes	☐ No
Any hot flashes or sweating at night?					☐	Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?					☐	Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?					☐	Yes	☐ No
Date of last pap?							
MEN ONLY							
Do you usually get up to urinate during the night?					☐	Yes	☐ No
If yes, # of times:							
Do you feel pain or burning with urination?					☐	Yes	☐ No
Any blood in your urine?					☐	Yes	☐ No
Do you feel burning discharge from penis?					☐	Yes	☐ No
Has the force of your urination decreased?					☐	Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?					☐	Yes	☐ No
Do you have any problems emptying your bladder completely?					☐	Yes	☐ No
Any difficulty with erection or ejaculation?					☐	Yes	☐ No
Any testicle pain or swelling?					☐	Yes	☐ No

OTHER PROBLEMS		
Check if you have, or have had, any symptoms in the following areas to a significant degree and briefly explain in the space below.		
☐ Skin	☐ Chest/Heart	☐ Recent changes in:
☐ Head/Neck	☐ Back	☐ Weight
☐ Ears	☐ Intestinal	☐ Energy level
☐ Nose	☐ Bladder	☐ Ability to sleep
☐ Throat	☐ Bowel	☐ Other pain/discomfort:
☐ Lungs	☐ Circulation	☐ Other odd symptom
Use this space to elaborate on the above chart or for anything else you would like to add not addressed in this form.		