Integrative Medicine
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New Patient Intake Form- Adult

Patient Demographic Information:

First Name: _____ Last Name: _____
Date of Birth: ___/_____/_____ Age: ____ Primary number: (____)_____
Secondary number: (____)_____ Email Address: _____
Mailing Address: _____

Primary Care Provider:

Physician Name: _____ Practice Name: _____
Address: _____
Phone Number: (___)_____ Fax Number: (____)_____

Insurance Information: (If you do not have insurance just write self pay)

Primary Insurance Name: _____
Policy Number:_____ Group Number: _____
Policy Effective Date: ___/____/_____ Policy Holder Name: _____
Policy Holder's Date of Birth: ____/____/_____

Secondary Insurance Name: _____
Policy Number:_____ Group Number: _____
Policy Effective Date: ___/____/_____ Policy Holder Name: _____
Policy Holder's Date of Birth: ____/____/_____

How did you hear about our practice? _____

Date of Evaluation: _____

Chief Concerns:

What are your chief concerns at this time?_____

_____

_____

History of Present Illness:

When did your symptoms first begin?_____

Have you been diagnosed with a condition? If so, how were you diagnosed (by questionnaire, observation, lab tests, scans, etc) _____

_____

_____

What treatments (medications, therapies, etc) have you tried in the past?

_____

_____

What treatments have been helpful or effective?_____

_____

Medication History:

What current medications are you on and for how long?_____

_____

_____

_____

Have you been on any of these medications before? Please circle any that apply:
Antibiotics__ Antacids or acid blockers__Steroid pills or shots___Birth control pills____

_____

Have you had any reactions to any medications or vaccines?_____

_____

Supplement History:

What current supplements are you on, if any?_____

_____

Past Medical History:

List any major illnesses, hospitalizations, surgeries or injuries you have had with approximate dates if possible_____

_____

_____

If you are female, list any pregnancies, miscarriages or stillbirths _____

_____

Behavioral Symptoms:

Please check any of these below that might apply to you:

- ❑ ADHD symptoms: inattention, hyperactivity, impulsivity, distractibility
- ❑ Difficulty with organization, beginning and/or finishing tasks or projects
- ❑ Oppositional/argumentative behavior
- ❑ Irritability, anger outbursts, aggressive behavior
- ❑ Nervousness, worrying a lot, panic attacks
- ❑ Mood swings with highs and lows frequently
- ❑ Depressive symptoms: withdrawn, tearfulness, low energy, loss of interest in activities that you enjoyed before
- ❑ Obsessive-compulsive behaviors
- ❑ Lack of drive, low motivation
- ❑ Socially aloof, difficulty initiating/maintaining conversations and relationships
- ❑ Sensitivity to loud or high-pitched noise/music, bright lights, touch, clothes, fabrics, smells, tastes and textures of foods
- ❑ Learning disabilities such as dyslexia
- ❑ Self-injurious behaviors, such as self-mutilation

Review of Systems:

Please check any of these below that might apply to you currently or in the past:

___Sleep problems
___Snoring at night
___Appetite problems
___Low or excessive energy
___ Problems with weight gain or loss
___Memory or cognitive issues
___Headaches
___Vision or hearing problems
___Sinus infections
___Frequent sore throat
___Swallowing difficulty
___Allergies, seasonal &/or indoor
___Skin rashes/infections
___Dry skin
___Seizures

___Thyroid or other neck swelling
___Swollen lymph nodes
___ Asthma/bronchitis/pneumonia
___ Chest pain or palpitations
___Bloating or discomfort after meals
___Acid reflux or heartburn
___Nausea or vomiting
___Recurrent diarrhea
___Constipation/ passage of hard stool
___Alternating diarrhea or constipation
___ Kidney or bladder infections
___Kidney stones
___Genital infections
___Joint/muscle pains or swelling
___Numbness/tingling of arms or legs

If you have any additional symptoms not mentioned above, please add here:_____

_____

Lifestyle:

1. Do you eat 3 meals a day? _____
2. Describe a typical breakfast, lunch, and dinner, and snack:_____

_____
_____
_____
_____
_____

3. How much tea or coffee do you drink daily, if any?_____
4. How much alcohol do you consume in a week, if any?_____
5. If you smoke cigarettes, how many packs a day do you smoke?_____
6. Do you smoke marijuana or use any other recreational drug?_____
7. Do you get to spend some time outdoors everyday? _____
   If yes, how much time do you spend outdoors on average?_____
8. Do you exercise on a regular basis?_____
9. Any Environmental exposures?_____
10. Current or past stressors?_____
11. Family History that concerns you:_____

_____
_____
_____
_____

12. Social History (family members, ages/pets, travel, occupation etc.) that could be helpful in your care:_____

_____
_____
_____
_____

Thank you!

Please be sure to bring your insurance cards, and any and all labs or test results that you have access to, to your appointment with you.