

Intake Form

NAME _____ DATE _____

Day Ph. # _____ Evening Ph. # _____ Cell: _____

1. Family physician and other physicians currently treating you (name, address and phone number)

Treating Physician _____ Phone #: _____

Referring Practitioner: _____ Phone #: _____

2. What brings you in today? _____

3. Please describe any symptoms you're having. Intensity (0-10, with 0 being healthy and 10 being the worst)

Symptom	Intensity (rate from 0-10, with 10 being the worst)	How often do you get the symptoms? (ex. 1x a week)	How long do the symptoms last? (ex. 2 hours)

4. Have you had any major life changes, surgeries, serious injuries, or illnesses in the last five years?

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

5. _____ Date: _____

5. Medical History: Please list anyone else in your family who has a history of this symptoms or other chronic health problems? _____

6. Use of non-prescription medication (e.g., aspirin, Tylenol, decongestants, sleep medications, nasal sprays, inhalers, diet pills, vitamins, other supplements).

Name: _____ Date: _____

7. Please check all that apply or have applied to you at any point in your life.

Allergies		Heart Disease	
Anemia		High Blood Pressure	
Asthma		Pace Maker	
Chronic Headache		Respiratory Illness other than Asthma	
Diabetes		Sleep Apnea	
Dizziness		Seizures	
Epilepsy		Substance Abuse	
Fainting		Thyroid Problems	

8. Use of stimulants and social drugs (please circle and describe frequency).

Alcohol _____ Cigarettes _____

Marijuana _____ Coffee _____

Tea _____ No Doz _____

Other Substances _____

9. Quality of **Sleep**: What time do you go to sleep? _____ What time do you wake up? _____

On average, do you sleep continuously through the night without waking? Yes No.

10. Do you need a stimulant like coffee, coke, etc. in the morning to help you wake up? Yes No.

11. How would you describe your **energy level on a typical day?** (ex. motivated, tired, hyper, etc)

Morning _____ Day _____ Evening _____

12. Nutritional habits (detailed description of one day's typical meals).

Breakfast _____

Lunch _____

Dinner _____

How often do you eat out? _____

13. Please provide a brief statement of what you hope to accomplish with our time together: _____
