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Patient Intake Form

PATIENT DETAILS

Today's Date

Full Name

Age

Sex

Social Security #

Date of Birth

Birth Order

CONTACT INFO

Address of Primary Insured

Address Line 2

City

State

Postal / Zip Code

Country

We will send an email confirmation for scheduled appointments.

Mobile Phone

Home Phone

Work Phone

Email

CURRENT MEDICAL TEAM

Primary Physician

Phone Number

OB/GYN

Phone Number

PHARMACY

Preferred Pharmacy

Pharmacy Address

Pharmacy Phone Number

REFERRED BY

Name

EMERGENCY CONTACT

Name

Relationship

Mobile Phone

Home Phone

INSURANCE

Name of Primary Insured

Relationship to Insured

Date of Birth of Primary Insured

Name of Insurance Carrier

Member ID #

Group ID #

Address – from the back of your insurance card

HEALTH HISTORY

What brings you to Tula Wellness? What concerns about your health do you have?

What are your health goals?

MEDICAL CONDITIONS

Please list the name and diagnosis date of any current medical conditions.

Please list the name and diagnosis date of any previous or childhood medical conditions.

DIAGNOSTIC STUDIES

Have you ever had diagnostic studies?

Last Date Done & Results (-/+)

Colonoscopy

Bone Density

Electrocardiogram

Other

SURGERIES & HOSPITALIZATIONS

Date Procedure

Date Procedure

Date Procedure

Family Health History

Please tell us about your family. Please include any family member with a history of tuberculosis, diabetes, cancer, emphysema, kidney disease, ulcer, nervous breakdown or gall bladder disease.

Mother

Health Status Age if Alive/Age at Death Cause of Death

Health Problem

Father

Health Status Age if Alive/Age at Death Cause of Death

Health Problem

Other family

Health Status Age if Alive/Age at Death Cause of Death

Health Problem

Additional information related to your Family Medical History you would like us to know:

SOCIAL AND SOCIOECONOMIC HISTORY

Occupation

Employer

Highest Degree Earned

Do you enjoy your job?

Why? / Why not?

Present Marital Status

Spouse / Partner's Name

Total # in Household, including children

What are your main interests and hobbies?

HABITS & LIFESTYLE

Do you eat breakfast?

YES

NO

Do you eat three meals a day?

YES

NO

Do you feel rested upon awakening?

YES

NO

Do you spend time outside?

YES

NO

Do you take vacation?

YES

NO

Average hours per night of sleep

Average hours per day of television

What do you do to relax/recreate/socialize/cope with stress?

What are the major stressors in your life?

When are you happiest? What gives you joy?

Alcohol Use

If yes, what kind?

If yes, how many per week?

Tobacco Use

If yes, how many packs?

If yes, are you interested in quitting?

Recreational Drug Use

If yes, what kind?

If yes, how many per week?

Have you ever felt that you ought to cut down on your drinking or drug use?

Do you get annoyed at criticism of your drinking or drug use?

Do you ever feel guilty about your drinking or drug use?

Do you ever drink for an early morning "eye opener"?

Do you feel safe in your surroundings?

Do you have a history of sexual abuse?

**Describe your energy level throughout a typical day rating on a scale of 1-10:
1=Extreme Fatigue/10=Feeling Great and Energized**

Early Morning

Mid Morning to Noon

Mid Afternoon

Evening

Please describe any associated food or drink cravings (sugar, coffee, cola, etc.):

Have you seen a practitioner of alternative medicine?

Please check any practices you have tried:

Acupuncture

Neuro-Linguistic Programming

Hypnosis

Fasting

Orthomolecular Biofeedback

Traditional Chinese Medicine

Yoga

Chelation Therapy

Aromatherapy

Nutritional Medicine

Light Therapy

Meditation

Herbal Medicine

Homeopathy

Environmental Medicine

Ayurvedic Medicine

Guided Imagery

Bodywork

Naturopathic Medicine

Other

WOMEN'S HEALTH HISTORY

Date of last menstrual period

Number of children

Children's ages

Age at start of periods

Age at end of periods/menopause

Menses

Check all that apply.

Regular

Irregular

Painful

Other

History of abnormal pap smears?

If yes, please explain follow-up and treatment you received.

History of breast surgery

If yes, please explain follow-up and treatment you received.

Date of last mammogram

Results of mammogram

Date of last pap smear

Results of pap smear

SEXUAL ACTIVITY

Sexual Orientation

Are you sexually active?

Birth control method

Do you practice safe sex?

ALLERGIES

Do you have an ALLERGY to a drug or other substance?

If yes, please describe.

CURRENT PRESCRIPTION MEDICATIONS

| Drug Name | Strength | Dosage |
|-----------|----------|--------|
|-----------|----------|--------|

SUPPLEMENTS AND OVER-THE-COUNTER

| Drug Name | Strength | Dosage |
|-----------|----------|--------|
|-----------|----------|--------|

IMMUNIZATIONS

| | | |
|-----------------------|-----------|---------------------|
| Measles/Mumps/Rubella | Polio | Tetanus & Diptheria |
| Chicken Pox | Pneumovax | Tetanus-Booster |
| DPT | Influenza | Hepatitis A |
| Series 1 | Series 2 | Hepatitis B |
| Series 1 | Series 2 | N/A |

ANTIBIOTICS

How often have you taken antibiotics?

| | | |
|--------------------|------|-------|
| Infant / Childhood | Teen | Adult |
|--------------------|------|-------|

Have often have you taken oral steroids?

| | | |
|--------------------|------|-------|
| Infant / Childhood | Teen | Adult |
|--------------------|------|-------|

TOXIC METALS

Have you ever been exposed to toxic metals in your job or home?

Do you have dental amalgams (silver fillings) or root canals?

EMOTIONAL WELL BEING

How well have things been going for you at school?

How well have things been going with close friends?

How well have things been going for with your children?

How well have things been going for you at your job?

How well have things been going for you with sex?

How well have things been going for you with your parents?

How well have things been going for you with your social life?

How well have things been going for your attitude?

How well have things been going for you with your spouse/partner?

NUTRITION EVALUATION

Please list all foods and drinks you have consumed in the past 24 hours. Include meals, snacks, beverages and condiments.

Food Items; How Prepared (Baked, Fried, etc.); Amount (Cups, Tablespoons, Ounces, etc.):

Is this a typical day?

How many servings of fruit do you eat/drink each day? Serving = 1 small piece of fruit, 1 cup canned or chopped fruit, 1 cup dried fruit.

Are you currently on a special diet?

If yes, please describe:

Do you eat red meat?

What kind?

How many times per week?

Do you have symptoms immediately after eating such as belching, bloating, sneezing, hives, etc.?

If yes, are these symptoms associated with any particular food or supplements?

Please name the food or supplement and the symptom(s); i.e. Milk = gas,diarrhea

Do you feel you have delayed symptoms after eating certain foods? (symptoms may not be evident for 24 hours or more) such as fatigue, muscle aches, sinus congestion, etc.)

Does skipping a meal greatly affect your symptoms?

Is there anything about your diet that we should know?

Have you ever had a food that you craved or really “binged” on over a period of time? (Food craving might be an indicator that you are allergic to that food)

If yes, what food?

Do you have an aversion to certain foods?

If yes, what foods?

REVIEW OF SYSTEMS

Please check any current symptoms you may have:

Constitutional

Recent Fever

Night Sweats

Hot Flashes

Unexplained Weight Loss/Gain

Decline in Libido

Cardiovascular

Chest Pain/Discomfort

Palpitations

Short of Breath with Exertion

Respiratory

Cough/Wheeze

Coughing up Blood

Genitourinary

Painful/Bloody Urination

Leaking Urine

Nighttime Urination

Unusual Vaginal Bleeding

Concern with Sexual Function

Skin

Rash

New or Change in Mole

Thin, Ridged or Splitting Nails

Gastrointestinal

Heartburn/Reflux

Blood or Change in Bowel Movement

Nausea/Vomiting/Diarrhea

Pain in Abdomen

Irritable Bowel Syndrome/Digestive Problems

Psychiatric

Anxiety/Stress

Sleep Problems

Depression

Irritability

Blood/Lymphatic

Unexplained Lumps

Easy Bruising/Bleeding

Ear/Nose/Throat

Difficulty Hearing

Hay Fever/Allergies

Trouble Swallowing

Endocrine

Cold/Heat Intolerance

Increased Thirst/Appetite

Eyes

Changes in Vision

Neurological

Headaches

Memory Loss

Fainting

Musculoskeletal

Muscle/Joint Pain

Recent Back Pain

MEDICAL SYMPTOM QUESTIONNAIRE

Rate each of the following symptoms based upon your typical health profile for the last 30 Days.

Point system:

0 = Never or almost never have the symptoms

1 = Occasionally (effect is not severe)

2 = Occasionally (effect is severe)

3 = Frequently (effect is not severe)

4 = Frequently (effect is severe)

At the bottom of each section, total the numbers from the symptoms. At the very end, tally the grand total.

HEAD

Headaches

Faintness

Dizziness

Insomnia

Total

← Add all the numbers in the HEAD section here

DIGESTIVE

Nausea/Vomiting/Diarrhea

Constipation

Bloated Feeling

Belching/Passing Gas

Heartburn

Intestinal/Stomach Pain

Total

← Add all the numbers in the DIGESTIVE section here

EYES

Watery/Itchy Eyes

**Swollen, Reddened
or Sticky Eyelids**

Bags or Dark Circles

**Blurred or Tunnel
Vision – not near- or far-
sightedness**

Total

← Add all the numbers in the EYES section here

EARS

Itchy Ears

Ear Aches or Infections

Drainage from Ear

ringing/Hearing Loss

Total

← Add all the numbers in the EARS section here

WEIGHT

Binge Eating/Drinking

Craving Certain Foods

Compulsive Eating

Water Retention

Underweight

Total

← Add all the numbers in the WEIGHT section here

ENERGY/ACTIVITY

Fatigue/Sluggishness

Apathy/Lethargy

Hyperactivity

Restlessness

Total

← Add all the numbers in the ENERGY/ACTIVITY section here

NOSE

Stuffy Nose

Sinus Problems

Hay Fever

Sneezing Attacks

Excessive Mucus Formation

Total

← Add all the numbers in the NOSE section here

MIND

**Confusion/Poor
Comprehension**

Poor Memory

Poor Concentration

Poor Physical Condition

Difficulty Making Decisions

Stuttering or Stammering

Slurred Speech

Total

← Add all the numbers in the MIND section here

EMOTIONS

Mood Swings

Anxiety/Fear/Nervousness

Anger/Irritability

Depression

Total

← Add all the numbers in the EMOTIONS section here

SKIN

Acne

Hives/Rashes/Dry Skin

Hair Loss

Excessive Sweating

Flushing/Hot Flashes

Excessive Sweating

Total

← Add all the numbers in the SKIN section here

JOINTS/MUSCLES

Pain or Aches in Joints

Arthritis

**Stiffness/Limitation
of Movement**

**Feeling of Weakness
or Tiredness**

Total

← Add all the numbers in the JOINTS/MUSCLES section here

OTHER

Frequent Illness

Frequent or Urgent Urination Genital Itch or Discharge

Total

← Add all the numbers in the FREQUENT ILLNESS section here

GRAND TOTAL

← Add all the TOTALS together here

Signature

Date