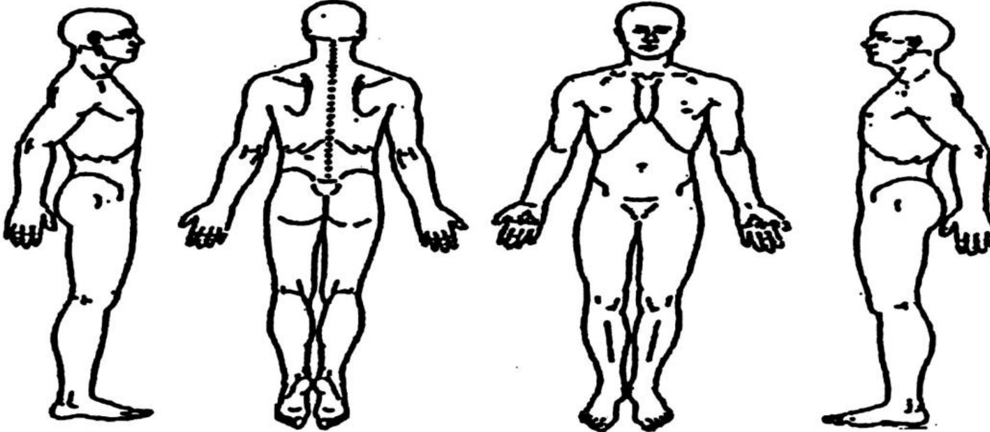
NEW PATIENT INTAKE FORM

Patient Name: ____Date:_________________

Address:____________________________City____________State_____Zip Code_______

1. Indicate on the drawings below where you have pain/symptoms



2. How often do you experience your symptoms?

□ Constantly (76-100% of the time) □ Occasionally (26-50% of the time)
□ Frequently (51-75% of the time) □ Intermittently (1-25% of the time)

3. How would you describe the type of pain?

□ Sharp □ Achy □ Stiff □ Sharp with motion
□ Dull □ Burning □ Numb □ Shooting with motion
□ Diffuse □ Shooting □ Tingly □ Stabbing with motion
□ Other ____________________________□ Electric like with motion

4. How are your symptoms changing with time?

□ Getting Worse □ Staying the Same □ Getting Better

5. Using a scale from 0-10 (10 being the worst), how would you rate your problem?

0 1 2 3 4 5 6 7 8 9 10 (*Please circle*)

6. How much has the problem interfered with your work?

□ Not at all □ A little bit □ Moderately □ Quite a bit □ Extremely

7. How much has the problem interfered with your social activities?

□ Not at all □ A little bit □ Moderately Quite a bit □ Extremely

8. Who else have you seen for your problem?

□ Chiropractor □ Neurologist □ Massage Therapist □ Primary Care Physician □ No one
□ ER physician □ Orthopedist □ Physical Therapist □ Other:_______________________

9. How long have you had this problem? ____

10. How do you think your problem began?

____

11. Do you consider this problem to be severe? □ Yes □ Yes, at times □ No

12. What aggravates your problem?

____

13. What concerns you the most about your problem; what does it prevent you from doing?

____

14. What is your: Height_______________Weight _____________ Date of Birth ____________
Occupation ____

15. How would you rate your overall Health?

□ Excellent □ Very Good □ Good □ Fair □ Poor

16. What type of exercise do you do?

□ Strenuous □ Moderate □ Light □ None

17. Indicate if you have any immediate family members with any of the following:

□ Rheumatoid Arthritis □ Diabetes □ Lupus
□ Heart Problems □ Cancer □ ALS

18. For each of the conditions listed below, place a check in the "past" column if you have had the condition in the past. If you presently have a condition listed below, place a check in the "present" column.

Past	Present	Past	Present	Past	Present
□	□ Headaches	□	□ High Blood Pressure	□	□ Diabetes
□	□ Neck Pain	□	□ Heart Attack	□	□ Excessive Thirst
□	□ Upper Back Pain	□	□ Chest Pains	□	□ Frequent Urination
□	□ Mid Back Pain	□	□ Stroke	□	□ Smoking/Tobacco Use
□	□ Low Back Pain	□	□ Angina	□	□ Drug/Alcohol Dependance
□	□ Shoulder Pain	□	□ Kidney Stones	□	□ Allergies
□	□ Elbow/Upper Arm Pain	□	□ Kidney Disorders	□	□ Depression
□	□ Wrist Pain	□	□ Bladder Infection	□	□ Systemic Lupus
□	□ Hand Pain	□	□ Painful Urination	□	□ Epilepsy
□	□ Hip Pain	□	□ Loss of Bladder Control	□	□ Dermatitis/Eczema/Rash
□	□ Upper Leg Pain	□	□ Prostate Problems	□	□ HIV/AIDS
□	□ Knee Pain	□	□ Abnormal Weight Gain/Loss		
□	□ Ankle/Foot Pain	□	□ Loss of Appetite	**For Females Only**	
□	□ Jaw Pain	□	□ Abdominal Pain	□	□ Birth Control Pills
□	□ Joint Pain/Stiffness	□	□ Thyroid	□	□ Hormonal Replacement
□	□ Arthritis	□	□ Hepatitis	□	□ Pregnancy
□	□ Rheumatoid Arthritis	□	□ Liver/Gall Bladder Disorder		
□	□ Cancer	□	□ General Fatigue		
□	□ Tumor	□	□ Muscular Incoordination		
□	□ Asthma	□	□ Visual Disturbances		
□	□ Chronic Sinusitis	□	□ Dizziness		
□	□ Other:____________________________				

19. Why do you think other doctors have not been able to help you achieve you goals?_____________

____

20. What are you most concerned with regarding your problem?________________________________

____

21. How has your health condition affected your job, relationships, finances, family, or other activities? ____

22. Anything else pertinent to your visit today?____

____

23. What do you desire most to get from working with us?

____

____

24. What do you think is a realistic time frame for you to see some improvement under our care?

____

Patient Signature____**Date:**________________________

Medications

Please list all drugs you are currently taking including over the counter drugs, aspirin, etc. Also list how long you have taken each drug and the condition for which it was prescribed.

DRUG	PRESCRIBED FOR:	DATE STARTED TAKING

Please list all vitamins/herbs/supplements you are currently taking. Also, list how much of each supplement and why you are taking it.

VITAMIN	REASON	HOW MUCH

Please type a detailed timeline of your medical history and return with this form.

Please include:

- The main problems/concerns or symptoms that you are experiencing. List them.
- When did these problems start? How have they changed over time?
- What have you tried to help this? (Medications, therapies, diet, supplements, etc.)
- What was the response? (helped, worse, no change)
- What do you think makes these symptoms worse?
- What do you think makes these symptoms better?
- TELL ME AS MUCH AS YOU CAN!

Metabolic Assessment Form

Name: ______________________ **Age:** ______ **Sex:** _____ **Date:** __________

Please list the 5 major health concerns in your order of importance:

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

Please circle the appropriate number "0 - 3" on all questions below. 0 as the least/never to 3 as the most/always.

Category I

Symptom				
Feeling that bowels do not empty completely	0	1	2	3
Lower abdominal pain relief by passing stool or gas	0	1	2	3
Alternating constipation and diarrhea	0	1	2	3
Diarrhea	0	1	2	3
Constipation	0	1	2	3
Hard, dry, or small stool	0	1	2	3
Coated tongue of "fuzzy" debris on tongue	0	1	2	3
Pass large amount of foul smelling gas	0	1	2	3
More than 3 bowel movements daily	0	1	2	3
Use laxatives frequently	0	1	2	3

Category II

Symptom				
Excessive belching, burping, or bloating	0	1	2	3
Gas immediately following a meal	0	1	2	3
Offensive breath	0	1	2	3
Difficult bowel movements	0	1	2	3
Sense of fullness during and after meals	0	1	2	3
Difficulty digesting fruits and vegetables; undigested foods found in stools	0	1	2	3

Category III

Symptom				
Stomach pain, burning, or aching 1- 4 hours after eating	0	1	2	3
Do you frequently use antacids?	0	1	2	3
Feeling hungry an hour or two after eating	0	1	2	3
Heartburn when lying down or bending forward	0	1	2	3
Temporary relief from antacids, food, milk, carbonated beverages	0	1	2	3
Digestive problems subside with rest and relaxation	0	1	2	3
Heartburn due to spicy foods, chocolate, citrus, peppers, alcohol, and caffeine	0	1	2	3

Category IV

Symptom				
Roughage and fiber cause constipation	0	1	2	3
Indigestion and fullness lasts 2-4 hours after eating	0	1	2	3
Pain, tenderness, soreness on left side under rib cage	0	1	2	3
Excessive passage of gas	0	1	2	3
Nausea and/or vomiting		1	2	3
Stool undigested, foul smelling, mucous-like, greasy, or poorly formed	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst and appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category V

Symptom				
Greasy or high fat foods cause distress	0	1	2	3
Lower bowel gas and or bloating several hours after eating	0	1	2	3
Bitter metallic taste in mouth, especially in the morning	0	1	2	3
Unexplained itchy skin	0	1	2	3
Yellowish cast to eyes	0	1	2	3
Stool color alternates from clay colored to normal brown	0	1	2	3
Reddened skin, especially palms	0	1	2	3
Dry or flaky skin and/or hair	0	1	2	3
History of gallbladder attacks or stones	0	1	2	3
Have you had your gallbladder removed	Yes	No		

Category VI

Symptom				
Crave sweets during the day	0	1	2	3
Irritable if meals are missed	0	1	2	3
Depend on coffee to keep yourself going or started	0	1	2	3
Get lightheaded if meals are missed	0	1	2	3
Eating relieves fatigue	0	1	2	3
Feel shaky, jittery, tremors	0	1	2	3
Agitated, easily upset, nervous	0	1	2	3
Poor memory, forgetful	0	1	2	3
Blurred vision	0	1	2	3

Category VII

Symptom				
Fatigue after meals	0	1	2	3
Crave sweets during the day	0	1	2	3
Eating sweets does not relieve cravings for sugar	0	1	2	3
Must have sweets after meals	0	1	2	3
Waist girth is equal or larger than hip girth	0	1	2	3
Frequent urination	0	1	2	3
Increased thirst & appetite	0	1	2	3
Difficulty losing weight	0	1	2	3

Category VIII

Symptom				
Cannot stay asleep	0	1	2	3
Crave salt	0	1	2	3
Slow starter in the morning	0	1	2	3
Afternoon fatigue	0	1	2	3
Dizziness when standing up quickly	0	1	2	3
Afternoon headaches	0	1	2	3
Headaches with exertion or stress	0	1	2	3
Weak nails	0	1	2	3

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Symptom groups listed in this flyer are not intended to be used as a diagnosis of any disease condition.
For nutritional purposes only

Category IX

Cannot fall asleep	0	1	2	3
Perspire easily	0	1	2	3
Under high amounts of stress	0	1	2	3
Weight gain when under stress	0	1	2	3
Wake up tired even after 6 or more hours of sleep	0	1	2	3
Excessive perspiration or perspiration with little or no activity	0	1	2	3

Category X

Tired, sluggish	0	1	2	3
Feel cold – hands, feet, all over	0	1	2	3
Require excessive amounts of sleep to function properly	0	1	2	3
Increase in weight gain even with low-calorie diet	0	1	2	3
Gain weight easily	0	1	2	3
Difficult, infrequent bowel movements	0	1	2	3
Depression, lack of motivation	0	1	2	3
Morning headaches that wear off as the day progresses	0	1	2	3
Outer third of eyebrow thins	0	1	2	3
Thinning of hair on scalp, face or genitals or excessive falling hair	0	1	2	3
Dryness of skin and/or scalp	0	1	2	3
Mental sluggishness	0	1	2	3

Heart palpations	0	1	2	3
Inward trembling	0	1	2	3
Increased pulse even at rest	0	1	2	3
Nervous and emotional	0	1	2	3
Insomnia	0	1	2	3
Night sweats	0	1	2	3
Difficulty gaining weight	0	1	2	3

Category XII

Diminished sex drive	0	1	2	3
Menstrual disorders or lack of menstruation	0	1	2	3
Increased ability to eat sugars without symptoms	0	1	2	3

Category XIII

Increased sex drive	0	1	2	3
Tolerance to sugars reduced	0	1	2	3
"Splitting" type headaches	0	1	2	3

Category XIV (Males only)

Urination difficulty or dribbling	0	1	2	3
Urination frequent	0	1	2	3
Pain inside of legs or heels	0	1	2	3
Feeling of incomplete bowel evacuation	0	1	2	3
Leg nervousness at night	0	1	2	3

Category XV (Males only)

Decrease in libido	0	1	2	3
Decrease in spontaneous morning erections	0	1	2	3
Decrease in fullness of erections	0	1	2	3
Difficulty in maintain morning erections	0	1	2	3
Spells of mental fatigue	0	1	2	3
Inability to concentrate	0	1	2	3
Episodes of depression	0	1	2	3
Muscle soreness	0	1	2	3
Decrease in physical stamina	0	1	2	3
Unexplained weight gain	0	1	2	3
Increase in fat distribution around chest and hips	0	1	2	3
Sweating attacks	0	1	2	3
More emotional than in the past	0	1	2	3

Category XVI (Menstruating Females Only)

Are you perimenopausal	Yes	No
Alternating menstrual cycle lengths	Yes	No
Extended menstrual cycle, greater than 32 days	Yes	No

Pain and cramping during periods	0	1	2	3
Scanty blood flow	0	1	2	3
Heavy blood flow	0	1	2	3
Breast pain and swelling during menses	0	1	2	3
Pelvic pain during menses	0	1	2	3
Irritable and depressed during menses	0	1	2	3
Acne break outs	0	1	2	3
Facial hair growth	0	1	2	3
Hair loss/thinning	0	1	2	3

Category XVII (Menopausal Females Only)

How many years have you been menopausal?

Since menopause, do you ever have uterine bleeding? **Yes** **No**

Hot flashes	0	1	2	3
Mental fogginess	0	1	2	3
Disinterest in sex	0	1	2	3
Mood swings	0	1	2	3
Depression	0	1	2	3
Painful intercourse	0	1	2	3
Shrinking breasts	0	1	2	3
Facial hair growth	0	1	2	3
Acne	0	1	2	3
Increased vaginal pain, dryness or itching	0	1	2	3

How many alcohol beverages do you consume per week? _________

How many caffeinated beverages do you consume per day? _________

How many times do you eat out per week? ___________

How many times a week do you eat raw nuts or seeds? _____________

How many times a week do you eat fish? ___________

How many times a week do you workout? ________________________

List the three worst foods you eat during the average week: _____________________, ______________________, _____________________

List the three healthiest foods you eat during the average week: _____________________, _____________________, ___________________

Do you smoke?________If yes, how many times a day: ____________

Rate your stress levels on a scale of 1-10 during the average week: __________________

Please list any medications you currently take and for what conditions:

Please list any natural supplements you currently take and for what conditions:

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CASE HISTORY

Whatever label has been given to you, keep in mind that is just a label. It doesn't tell us what to do. Your answers to these questions and the results of your examination will tell me how to help you as fast as possible. I look forward to working with you.

Name ________________________________Date of birth ____________Date _____________

Address_________________________________City________________Zip______________

Home phone ______________Cell Phone _______________Work phone _________________

E-mail_____________________________________Social Security #____________________

Employer_________________________Occupation________________Marital Status______

In case of emergency, notify: ____

Has there been any diagnosis of your symptoms/conditions? ☐ Yes ☐ No

If yes, please list the diagnosis, who made the diagnosis and the date diagnosis was made:

____

____

Have you ever been diagnosed with an auto-immune condition? Yes ______ No ______

Please circle any conditions that you or any family member has been diagnosed with:

Hashimotos Sjorgens Lupus Sclerodema Addisons

Pernicious anemia Raynauds Type I Diabetes Rheumatoid arthritis

History of concussion? _____What side of your head? _____History of stroke? _____

What side of your brain? _____Do you have difficulty understanding what others say to

you? _____Do you have difficulty being comfortable in social situations? _____

Hobbies: Art__________Music _________Sports__________Games____________

Are you ☐ right handed ☐ left handed ☐ switches with different activities
☐ was left handed, but now is right ☐ was right handed, but now is left

Your group insurance company____
Insured____________________________Policy #_______________________________
Address____

*****Write down EVERYTHING you eat & drink for 3 days. What you're eating and when you're eating can have a HUGE NEGATIVE EFFECT on your health.****

Day 1

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack Time:	Snack Time:	Snack Time:

Day 2

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack Time:	Snack Time:	Snack Time:

Day 3

Breakfast	Lunch	Dinner
Time:	Time:	Time:
Snack Time:	Snack Time:	Snack Time: