Health for Everyone

Patient Intake Form

Name	**Date of Birth**	**Appointment Date/Time**

Adress	**City**	**State, Zip**

Email	**Phone**	**Phone**

Which Doctor are you seeing?

Dr. _____ _____

My goal is to get a sense of who you are as a person, to understand the important relationships and events in your life, in addition to the medical condition that brings you in today. This understanding, in our experience, can lead to real change that can precipitate healing.

The interview serves to gain an understanding of the person, his or her medical condition, and his or her goals for the visit.

There are no right or wrong answers to some questions, and some of them may require a bit of thought. Take your time and answer each question to the best of your ability based on your self-care practices right now.

For some questions, please rank each item on a scale of 0–5.

0 – Never; 1 – Rarely; 2 – Sometimes; 3 – Often; 4 – Regularly; 5 – Always.

TELL ME YOUR STORY.

What are you goals for this visit?

	Concern (please rank by priority) **ex.**headaches	**Onset** **Ex.** june 2012	**Frequency** **Ex.** 4 time/week	**Severity** Mild/mod/severe
1				
2				
3				
4				
5				
6				
7				
8				

Medical History

Please indicate if you have/or have ever had:

Name	**Past Yes/Not**	**Present Yes/Not**	**List family members who have had these illnesses (siblings, parent, children, grandparent)**
Heart Disease (including heart attacks)			
Hypertension			
Cancer			
Diabetes			
Lung Disease (asthma, etc)			

Hepatitis			
Digestive Disorders			
Seizures			
Tyroid Disease			
Severe mental illness			
Past or recent physical injuries, including fractures or dislocations			
Glaucoma			
Retinal detachment			
Epilepsy			
Osteoporosis			
Other			

Coments

Allergic reaction to medications

Medication	**Reacti**	**On/ Intolerances**

Operations/Injuries

Operations		Injuries	
What	**When**	**What**	**When**

Coments

Ocupation:

What hobbies/interests do you have?

Hold a work position in an area of your interest?

0 1 2 3 4 5

Work in a position that matches your professional goals?

0 1 2 3 4 5

Find a sense of meaning and enjoyment in your work?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Empathize and connect with customers, clients, and work colleagues?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have confidence in your ability to address challenges in your professional life?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel supported at work or in your professional life?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have someone you can rely on if you need help or guidance?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Set limits at work, whether it be with clients or tasks?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Disengage and leave pressures behind at the end of the day?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Take vacation or holiday breaks to allow for some down time?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Who do you live with? (include roommates, friends, partner, spouse, children, parents, relatives, pets**)**

Name	**Age**	**Relationship**

What physical activity do you participate in?

Eat a whole foods-based diet rich in colorful fruits and vegetables?

0 1 2 3 4 5

Drink enough water?

0 1 2 3 4 5

Exercise for more than 20 minutes?

0 1 2 3 4 5

Wake feeling refreshed from sleep?

0 1 2 3 4 5

Sleep at least 7 hours per night?

0 1 2 3 4 5

Make time to relax or nap?

0 1 2 3 4 5

Take time to breathe deeply throughout the day?

0 1 2 3 4 5

Engage in stress-reducing activities (excluding TV or screen time)?

0 1 2 3 4 5

Spend time in nature?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel nourished, healthy, and strong?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

What are the major stressors in your life?

What do you do to relax?

Make time to participate in things you enjoy?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Give and receive affection regularly?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel understood and valued by those who are close to you?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel gratitude on a daily basis?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Find meaning in life even during difficult times?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Take an interest in or find joy in the world around you?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have hope that things will get better?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Express yourself creatively?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Treat yourself with kindness?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Remember to make your dreams and goals a priority?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have a dependable person who listens to you?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have supportive family and friends close by?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Get enough social time with people who make you happy?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Participate in group activities with people who share a common interest?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Spend time with people who make you laugh?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel like your close relationships are loving and supportive?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Have the ability to comfortably say no?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Do something fun with family or friends at least once a week?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel like your personal life brings balance to your professional life?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Feel comfortable asking for help when you need it?

0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐

Religious affiliation, past and present

S	Spiritual belief system—What is your formal religious affiliation?
P	Personal spirituality—Describe the beliefs and practices of your religion or spiritual system that you personally accept/do not accept.
I	Integration within a spiritual community—Do you belong to a spiritual or religious group or community? What importance does this group have for you?
R	Ritualized practices and restrictions—Are there specific practices that you carry out as part of your religion/spirituality (e.g., prayer and meditation)? What significance do these practices or restrictions have to you?
I	Implications for medical care—What aspects of your religion/spirituality would you like me to keep in mind as I care for you?
T	Terminal events planning—As we plan for your care near the end of life, how does your faith impact on your decisions?

S ☐

P ☐

I ☐

R ☐

I ☐

T ☐

What prior experiences have you had with alternative medicine?

Tobacco

☐ Never Used ☐ Smoked from age ☐ to ☐ ☐ packs per day.

Alcohol

☐ Never Used ☐ Estimated drinks per day ☐

Recreational Drugs

☐ Never Used ☐ Frequency ☐

Coments:

What medications are you taking now? (include prescription and over - the counter drugs)

Medication	Reason	When	Started	Dosage per day	Cost

What vitamins/minerals/supplements are you taking now?

Brand or other name (manufacturer)	Reason	When started	Dosage per day	Cost

Nutrition evaluation

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

Food Item	**How prepared (baked, fried etc)**	**Amount(cup, tbs, ounces etc)**

Is a typical day? If not, why? Please describe

How many servings of fruit do you eat/drink per day?(serving=1 small piece of fruit, 1/2 cup juice, 1/2 canned or chopped fruit, 1/2 cup dried fruit**)**

How many servings of vegetables do you consume each day? (serving=1/2 cup raw or cooked vegetables, 1 cup fresh, green leafy vegetables, 1/4 cup dried vegetables, or 1 small piece**)**

Are you currently on a special diet? If so, please describe:

What type of oil or spreads do you add to your food?

What do you drink on a typical day?

How would you describe your relationship with food?

Traumatic experiences

In my life I have experienced...

Alcoholic or drug abusing parent(s) ☐ yes ☐ no ☐ I don't know

Sexual abuse from a non-family member ☐ yes ☐ no ☐ I don't know

Sexual abuse from parent or family caretaker ☐ yes ☐ no ☐ I don't know

Sexual abuse from family peer ☐ yes ☐ no ☐ I don't know

(brother, sister, cousin)

Rape before I was 18 ☐ yes ☐ no ☐ I don't know

Rape after I was 18 ☐ yes ☐ no ☐ I don't know

Physical beatings or other abuse as a child ☐ yes ☐ no ☐ I don't know

Emotional abuse as a child ☐ yes ☐ no ☐ I don't know

Near-death experience ☐ yes ☐ no ☐ I don't know

(please explain)

Severe illness ☐ yes ☐ no ☐ I don't know

Severe accident or injury ☐ yes ☐ no ☐ I don't know

Other traumatic event(s) (please explain) ☐ yes ☐ no ☐ I don't know

What I know about my own birth is....

It was a natural (no drugs) birth ☐ yes ☐ no ☐ I don't know

My mother was anesthetized ☐ yes ☐ no ☐ I don't know

It was a long labor ☐ yes ☐ no ☐ I don't know

It was a caesarian birth ☐ yes ☐ no ☐ I don't know

I was breastfed ☐ yes ☐ no ☐ I don't know

My mother was using drugs/alcohol during

pregnancy ☐ yes ☐ no ☐ I don't know

My mother was in an abusive situatio

while she was pregnant with me ☐ yes ☐ no ☐ I don't know

There were complications in my delivery ☐ yes ☐ no ☐ I don't know

If so, what

Observations on questions with scores:

The higher the score, the better you may be at taking time for self-care and wellness in each aspect of your life.

Trying to improve your scores can help create more balance in your life.

Consider items on which you scored 3 or lower. How can you modify your behavior to improve your self-care practices?

What goals might you need to set in order to make these changes?

SUBMIT