Medical Intake Form

Please complete all of the following as accurately as possible:

Name _____ Age _____ Birthdate _____ Sex _____

Address _____ City _____ Zip _____

Phone (H) _____ _____ (W) _____ _____

Occupation _____ Full Time / Part Time

Employer _____ Education Level _____

Married _____ Separated _____ Divorced _____ Widow _____ Single _____ Other _____

Children (ages) _____

How did you hear about us? _____

Are you familiar with Homeopathy? _____

What is the Level of Your Health? Excellent _____ Good _____ Fair _____ Poor _____

Please list your most concerning health care problems at this time (in order of importance to you):

1. _____
2. _____
3. _____
4. _____
5. _____

When did your chief problem or illness begin? _____

What do you think may have caused your chief complaint?

_____

What experiences in your life have affected you deeply?

_____

_____

Past Surgical History:

Please list any Surgical Procedures you have had and the approximate dates:

	Problem	***Dates***
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Past Medical History:

Please list any serious medical conditions for which you have been treated / hospitalized in the past:

	Problem	***Dates***
1.	_____	_____
2.	_____	_____
3.	_____	_____
4.	_____	_____
5.	_____	_____

Specifically, please place a check next to any of the following that you have had:

_____ Heart Disease
_____ Stroke
_____ Diabetes
_____ Hypertension
_____ Asthma
_____ Allergies
_____ Eczema
_____ Depression
_____ Sexually Transmitted Disease
_____ HIV / AIDS
_____ Tuberculosis (TB)
_____ Polio
_____ Cancer
_____ Major Trauma

Family History:
Please Circle any of the following diseases tend to run in your family and list what relative (father, grandmother, etc.)

Diabetes: _____ Cancer: _____

Heart Disease: _____ Asthma: _____

Stroke: _____ Allergies: _____

High Blood Pressure: _____ Eczema: _____

Seizures: _____ Blood disorder: _____

Social History:
Please check beside any of the following you have used in the past or currently:

_____ Alcohol (beer, wine or spirits)
_____ Illegal Drugs
_____ Birth Control Pills
_____ Vitamins / Supplements
_____ Tobacco (cigarettes, cigar, pipe)
_____ Tobacco (chewing)
_____ Coffee
_____ Herbal Products

Medications:
List all of the Prescription Medicines or Over the Counter Drugs you are now taking:

_____

_____

Allergies:
Please list any medications to which you are allergic:

_____

Please list any foods that you are allergic or sensitive:

_____

Food Cravings:
Please list any strong food cravings or favorite foods:

_____

Please list any strong food aversion or foods you avoid:

_____

Review of Systems:
Please put a check in the space next to any symptoms you currently have, or have had in the past:

General:

Now	Past		Now	Past	
____	____	Warm blooded person	____	____	Thirsty
____	____	Chilly person	____	____	No thirst
____	____	Tend to perspire easily	____	____	Weight loss or gain
____	____	Sensitive to wind	____	____	Affected by change in weather

HEENT:

Now	Past		Now	Past	
____	____	Headaches	____	____	Eye Problem
____	____	Hair Loss	____	____	Sensitive to Light
____	____	Head Injury	____	____	Sinus infections
____	____	Seizures	____	____	Nose Allergy
____	____	Dizziness	____	____	Loss of Smell
____	____	Vertigo	____	____	Frequent cavities
____	____	Balance Problem	____	____	Teeth problems
____	____	Hearing Problem	____	____	Grinding the teeth
____	____	Ringing in Ear	____	____	Mouth Ulcers
____	____	Sensitive to Noise	____	____	Gum problems
____	____	Ear Infections	____	____	Taste in mouth
____	____	Discharge from Ear	____	____	Loss of taste
____	____	Retina Problems	____	____	Sore throats
____	____	Wear Glasses	____	____	Swallowing problem
____	____	Glaucoma	____	____	Tonsillitis
____	____	Cataracts	____	____	Loss of voice

Neck:

Now	Past		Now	Past	
____	____	Neck Injury	____	____	Thyroid Problem
____	____	Neck Pain	____	____	Swollen glands

Respiratory:

Now	Past		Now	Past	
____	____	Asthma	____	____	Wheezing
____	____	Pneumonia	____	____	Phlegm (frequent)
____	____	Bronchitis	____	____	Short of Breath
____	____	Persistent Cough	____	____	Fluid in Chest

Heart:

Now	Past				
____	____	Heart Attack	____	____	Chest Tightness
____	____	Angina	____	____	Palpitations
____	____	Heart Valve Problem	____	____	Irregular Heartbeat
____	____	Chest Pain	____	____	Ankle or leg swelling

GI:

Now	Past				
____	____	Stomach Ulcer	____	____	Bloating
____	____	Gastritis	____	____	Diarrhea Tendency
____	____	Reflux	____	____	Constipation Tendency
____	____	Heartburn	____	____	Blood in Stool
____	____	Frequent Nausea	____	____	Hemorrhoids
____	____	Frequent Vomiting	____	____	Fissures
____	____	Indigestion	____	____	Rectal Itching
____	____	Belching	____	____	Parasites
____	____	Gas	____	____	Liver Problems

GU:

Now	Past				
____	____	Frequent Urination	____	____	Waking to Urinate
____	____	Painful Urination	____	____	Incontinence
____	____	Difficulty urinating	____	____	Blood in Urine

Male

____	____	Prostate problems	____	____	Testicle pain or swelling
____	____	Erection problems	____	____	Infertility
____	____	Discharge from Penis	____	____	Varicocele

Female

____	____	Vaginal discharge	____	____	Long lasting periods
____	____	Few or No orgasms	____	____	Bleeding between periods
____	____	Painful Intercourse	____	____	Fibroids
____	____	Vaginal itching	____	____	Ovarian Cysts
____	____	Premenstrual Syndrome (PMS)	____	____	Endometriosis
____	____	Heavy periods	____	____	Menopausal problems
____	____	Irregular periods			

Age menstruation began: _____
How frequent are periods: every _____ days How long do Periods usually last? _____ days

Number of Pregnancies _____ Number of Births _____ Miscarriages _____ Abortions _____

Musculoskeletal:

Now	Past		Now	Past	
____	____	Muscle pain	____	____	Broken Bones
____	____	Joint pain	____	____	Numbness or Tingling
____	____	Bone pain	____	____	Weakness in arms/legs

Skin:

Now	Past		Now	Past	
____	____	Rough or Dry skin	____	____	Hives
____	____	Rashes	____	____	Boils / Abcesses
____	____	Itching	____	____	Acne
____	____	Warts	____	____	Nail problems

Sleep:

Now	Past		Now	Past	
____	____	Difficulty falling asleep	____	____	Waking too early
____	____	Nightmares	____	____	Sleep apnea
____	____	Waking frequently			

Mental / Emotional

Now	Past		Now	Past	
____	____	Memory problems	____	____	Irritability
____	____	Confusion	____	____	Anger problems
____	____	Difficulty Concentrating	____	____	Mood Swings
____	____	Impulsive	____	____	Depression / Sadness
____	____	Restlessness	____	____	Hallucinations
____	____	Nervousness / Anxiety	____	____	Feelings of Euphoria
____	____	Strong fears			

Please list any specific Fears that you have: _____

_____

Please provide any further clarifying information here: _____

_____

_____

_____