Scottsdale Restorative Medicine
10304 N Hayden Rd St.1, Scottsdale AZ 85258
Phone: 480-273-2006 **Fax**: 480-991-9270

Welcome…

We are Excited you are taking the first steps to the new you. I hope your experience will be as fun and rewarding as those before you.

Dr Aaron Stowell

Patient Intake Form

Date:_____

Patient Name (First):_____ (Middle)_____ (Last) _____
Address: _____City:_____
State:_____ Zip:_____ Email:_____
Sex: □Male □ Female Age:_____ Birth Date:_____ Phone#:_____

These questions refer to your current status:. Marital status: □ Single □ Married□ Divorced □ Widowed
Number of children: _____ Number living in your household: _____
Occupation: _____
Alcohol consumption: drinks/week: _____
Smokers: Currently smoke: _____at _____per day (What)
Previously smoked: _____at _____per day (What)
For: _____(years).
Current recreational drug use _____
Coffee: Cups/day: _____
Diet soda or other drinks with aspartame/day: _____
Water, 8 oz. cups/day: _____

Are you currently experiencing the following symptoms to a degree you consider substantial or unusual? If you check Yes, please describe how long and if you have received treatment.

Headaches □Yes □ No
Visual problems □Yes □ No
Hearing loss □Yes □ No
Ringing in ears □Yes □ No
Sore throat □Yes □ No
Allergy symptoms (nasal congestion, watery eyes, post nasal drip?) □Yes □ No
Loss of smell or taste □Yes □ No
Lumps in neck, armpits, groin or breast □Yes □ No
Chest pain □Yes □ No
Shortness of breath at rest □Yes □ No
Shortness of breath with exertion □Yes □ No
Palpitations □Yes □ No
Abdominal pain □Yes □ No
Diarrhea □Yes □ No

Scottsdale Restorative Medicine
10304 N Hayden Rd St.1, Scottsdale AZ 85258
Phone: 480-273-2006 **Fax**: 480-991-9270

Constipation (hard or effortful bowel movements?) □Yes □ No
Blood in stool or black stool □Yes □ No
Difficulty urinating □Yes □ No
Leaking urine □Yes □ No
Genital discharge or sores □Yes □ No
Urinating at night □Yes □ No
Specify times/night: _____
Muscle, bone or joint pain □Yes □ No
Specify locations of Joint pain : _____
_____
_____

FEMALES ONLY
Missed periods □Yes □ No
Pelvic soreness □Yes □ No
Menstrual pain □Yes □ No
Heavy menstrual bleeding □Yes □ No
Hot flashes □Yes □ No
Abnormal Pap smear □Yes □ No
Infertile. Form of birth control: None Pill IUD Sponge Foam Condom □Yes □ No
Diaphragm other: _____
Date of last: Menstrual period: _____ Breast exam: _____
Pap smear: _____ Mammogram: _____

MALES AND FEMALES
Date of last: Colonoscopy (or sigmoidoscopy): _____ Rectal Exam: _____
Stress EKG (treadmill stress test): _____ Chest x-ray: _____
Were any of the above tests abnormal? Please describe:
_____
_____
_____

YOUR GOALS
What are your most important expectations as a patient: _____
_____
_____

CURRENT EXERCISE SUMMARY
How often do you engage in aerobic exercise (walking, jogging, biking, swimming)?
Times/week:_____
Please describe your routine:_____

How often do you engage in flexibility and/or stretching exercises (yoga, tai chi, stretch & toning classes, brief stretching after aerobics or weights)?

Scottsdale Restorative Medicine
10304 N Hayden Rd St.1, Scottsdale AZ 85258
Phone: 480-273-2006 **Fax**: 480-991-9270

Times/week: _____
_____

Are you currently a member of a health club?
Have you ever worked with a professional trainer?
If "Yes", for how long? _____
Are you still with a personal trainer □Yes □ No
If "Yes" to previous question , did you enjoy working with a trainer?
Do you have any exercise equipment at home (bike, treadmill,
free weights, etc.)?
If "Yes", what type?

_____
_____

Are you presently receiving physical therapy?
If "Yes", please describe: _____
If exercise is not part of your weekly routine, please explain why: (circle)
Lack of time - No motivation - Physical limitations
Unsure of what to - do Don't enjoy it - Other:

_____
_____

SUPPLEMENTATION
Are you taking vitamins, minerals or herbs on a regular basis? Yes No
If yes, please list what you are taking or copy labels and send in with questionnaire.

_____
_____
_____
_____
_____

Current Medications: prescribed by a physician as well as over the counter medications. If additional room is need please attach a list.

_____
_____
_____
_____

Drug Allergies:_____
_____

SYMPTOMS
Check the box that best describes the following symptoms you might have:
Water retention) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Inflamed or bleeding gums) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Nosebleeds) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**

Scottsdale Restorative Medicine
10304 N Hayden Rd St.1, Scottsdale AZ 85258
Phone: 480-273-2006 **Fax**: 480-991-9270

Indigestion after eating) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Flatulene (gas)) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Allergy or food sensitivities) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Please List Allergies: _____
_____
_____
_____

Lactose intolerance) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Dependency on antacids) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Toe and fingernail fungus) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Boils or sty's) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Vaginal yeast infection (women) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Jock itch (men)) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /** ☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Bad breath (no relief by brushing)) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Body odor (no relief by washing)) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Memory problems) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Energy loss) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Decreased self-image) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Back/spine problems) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Please describe _____
_____
_____

Sleep problems) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Poor concentration) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Rapid mood swings) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Impatient, moody, nervous) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Lack of mental alertness) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Depression) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Dry/flaky hair and/or dry brittle skin) ☐**Never** ☐ **Rare** ☐**Occasional** ☐**Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Acne) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Hair thinning or falling out) ☐**Never** ☐ **Rare** ☐ **Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Premenstrual tension (females only)) ☐**Never** ☐ **Rare** ☐**Occasional** ☐ **Often /**☐ **Mild/** ☐**Moderate/** ☐ **Severe**
Any other health issue that is causing you problems or you would like discuss?_____
_____
_____

Scottsdale Restorative Medicine
10304 N Hayden Rd St.1, Scottsdale AZ 85258
Phone: 480-273-2006 **Fax**: 480-991-9270

YOUR PHYSICIAN(S) INFORMATION:

NAME:_____ PHONE: _____
ADDRESS:_____ FAX: _____
CITY: _____ STATE:_____ZIP:_____
Additional Physicians that you are under care list below. If needed attach an additional sheet.
NAME:_____ PHONE: _____
ADDRESS:_____ FAX: _____
CITY: _____ STATE:_____ZIP:_____

Please Fax back to: 480-991-9270

We look Forward to Meeting You..

Scottsdale Restorative Medicine