Medical Health Intake

Page 1

Todays Date ________________ Name ____ Birth date ____________________

Occupation __________________________________ How Did You Hear about us ____

Purpose(s) for Todays Visit ____

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☑ **Requested Service** (Or Wanting Additional Info on Other Services)

- ☐ Chiropractic
- ☐ Naturopathic
  - ☐ General Health
  - ☐ Specific Illness
  - ☐ Homeopathy
- ☐ Massage
- ☐ Acupuncture
- ☐ Cupping

- ☐ Hormone Therapy
  - ☐ Pellets
  - ☐ Injections
  - ☐ Cream
- ☐ Weight Loss
  - ☐ Diet Nutrition Plan
  - ☐ Appetite Control
  - ☐ HCG Diet

- ☐ Vitamins Therapies
  - ☐ Injections
  - ☐ IV's
  - ☐ Supplements
- ☐ Other______________________

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Medical History

List Any Sugeries and or Hospitalizations with Dates ____

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Family Current Health Conditions and History of Illnesses for Grandparents, Parents and Siblings ___________________________

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Primary Care Provider ____ Date of Last visit ____________________

Reason for Last visit ____

Medications (prescription & nonprescription)____

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Allergies (Drug, Food or Other) and reactions ____

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Alcohol and/or Tobacco: Frequency/ Quantity / Duration: ____

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Caffeine __________________________________ Other Recreational Drugs ____

Exercise Frequency and Type ____

Diet Description ____

Doctor Notes ____

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☑ Symptoms Present Past Year

General
- ☐ Chills
- ☐ Depression/Nervousness
- ☐ Dizziness/Fainting
- ☐ Forgetfulness
- ☐ Headache
- ☐ Loss of Sleep
- ☐ Loss of weight
- ☐ Numbness
- ☐ Sweats

Muscle/Joints/Bone
Pain, Weakness, Numbness in:
- ☐ Arm
- ☐ Hips
- ☐ Back
- ☐ Legs
- ☐ Feet
- ☐ Neck
- ☐ Hands
- ☐ Shoulders

Genito-Urinary
- ☐ Blood in Urine
- ☐ Frequent Urination
- ☐ Lack of Bladder Control
- ☐ Painful Urination

Gastrointestinal
- ☐ Appetite Poor
- ☐ Bloating
- ☐ Bowel Changes
- ☐ Constipation
- ☐ Diarrhea
- ☐ Excessive Thirst
- ☐ Gas
- ☐ Hemorrhoids
- ☐ Indigestion
- ☐ Nausea
- ☐ Rectal Bleeding
- ☐ Stomach Pain
- ☐ Vomiting
- ☐ Vomiting Blood

Cardiovascular
- ☐ Chest Pain
- ☐ High/Low Blood Pressure
- ☐ Irregular/Rapid Heart Beat
- ☐ Poor Circulation
- ☐ Swelling of Ankles
- ☐ Varicose Vein

Eye, Ear, Nose & Throat
- ☐ Bleeding Gums
- ☐ Blurred Vision
- ☐ Crossed Eyes
- ☐ Difficulty Swallowing
- ☐ Double Vision
- ☐ Earache / Ear Discharge
- ☐ Hay Fever
- ☐ Hoarseness
- ☐ Loss of Hearing
- ☐ Nosebleed
- ☐ Persistent Cough
- ☐ Ringing in Ears
- ☐ Sinus Problem
- ☐ Vision – Flashes/Halos

Skin
- ☐ Bruise Easy
- ☐ Hives
- ☐ Itching/Rash
- ☐ Change in Moles
- ☐ Scars or Keloiding
- ☐ Sore that won't Heal

Men Only
- ☐ Erection Difficulty
- ☐ Lump in Testicles
- ☐ Penis Discharge
- ☐ Sore on Penis
- ☐ Other

Women Only
- ☐ Abnormal Pap Smear
- ☐ Bleeding Between Periods
- ☐ Breast Lump
- ☐ Extreme Menstrual Pain
- ☐ Hot Flashes
- ☐ Nipple discharge
- ☐ Painful Intercourse
- ☐ Vaginal Discharge
- ☐ Other

Date of Last:
- ☐ Menstrual Period____________
- ☐ Pap Smear __________________
- ☐ Mammogram _______________
- ☐ Pregnant
- ☐ Number of Children _________

Check Box ☑ if You Have or Had any of the Following Conditions:

- ☐ AIDS
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Breast Lump
- ☐ Cancer
- ☐ Cataracts
- ☐ Chemical Dependency
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Glaucoma
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV Positive
- ☐ Kidney Disease
- ☐ Liver Disease
- ☐ Migraine Headaches
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Problem
- ☐ Rheumatic Fever
- ☐ Scarlet Fever
- ☐ Stroke
- ☐ Thyroid Problems
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Venereal Disease
- ☐ Other________________

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Additional Information Not Mentioned or Questions ____
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Please Print/Sign acknowledging: To the best of my knowledge the information above is complete and correct. I understand that it is my responsibility to inform the doctor if I, or my minor child, ever have a change in health. Guardian or Personal Representative **Print/Sign** and Indicate Relationship below.

Print ____ Sign ____ Date _______________

Relationship (if signed by other than the Patient)____

Doctor Notes ____
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