Alliance
Integrative Medicine

INTAKE FORM

Patient Name: _____ Date of Birth _____ Date: _____

1. Tell us why you are here:
   □ For general health and well-being □ For a particular concern
   Specify: _____
   _____
2. If you are here for pain, please describe:
   a. Area of pain _____
   b. Length of time you have had this pain _____
   c. Diagnosis received _____
   _____
   _____
   d. Do you recall any specific incident at the time of onset, or prior to onset of pain, that you feel is associated with your condition? _____
   _____
   _____
   e. The pain is: □ Constant □ Intermittent □ Improving □ Worsening
   f. Symptoms are worse in the: □ morning □ afternoon □ night □ increase or □ decrease during the day
   g. The pain interferes with my:
   □ Work □ Sleep □ Daily Routine □ Sexual Activity □ Recreation □ Other _____
   h. Rate the pain on a scale of 1 to 10 (0 = no pain, 10 = worse possible pain) _____
   i. Symptoms are: □ Sharp □ Dull □ Burning □ Aching □ Throbbing □ Numbness □ Tingling
   j. Do your symptoms radiate? _____
   k. Things that aggravate the pain: _____
   l. Things that relieve the pain: _____
3. List health practitioners seen for this condition, treatments received, and effectiveness: _____
   _____
   _____
4. List previous surgeries (including cosmetic surgery): (Attach list if more than 5)
   _____ Date _____
   _____ Date _____
   _____ Date _____
   _____ Date _____
   _____ Date _____
5. Any other hospitalizations, accidents, injuries, broken bones or significant problems:
   _____ Date _____
   _____ Date _____
   _____ Date _____
6. Medical History: (Example: high cholesterol, diabetes, etc. Attach list if more than 4)
   _____ Date _____
   _____ Date _____
   _____ Date _____
   _____ Date _____

7. Drug/Food/Environmental Allergies _____ □ Latex Allergy: Y / N

8. Current medications **and doses**, including over the counter medications:

1.	7.
2.	8.
3.	9.
4.	10.
5.	11.
6.	12.

9. List all supplements & brand:

1.	5.
2.	6.
3.	7.
4.	8.

10. Diet: □ Low Fat □ Gluten-Free □ Dairy-Free

□ Regular (eats anything) □ Paleo / Ketogenic □ Vegetarian / Vegan

□ Dining Out > 3 meals/week □ Other: _____

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

Typical Snacks & Drinks: _____

Number of bowel movements per day/week:_____

11. Indicate approximate dates and the nature of any traumatic experience you have had. (e.g. death in family, divorce, change of residence, job loss, sexual assult, etc.)

_____ Date _____

_____ Date _____

_____ Date _____

12. Do you suffer from:

□ Fatigue □ Sleep problems □ Irritability

□ Moodiness or depression □ Appetite or weight changes □ Lack of enjoyment in life

□ Memory problems □ Anxiety

□ Compulsive behavior (e.g. binge eating, hand washing, checking locked doors, etc.)

13. Do you:

a. Get along with people outside your family	□ Yes	□ No
b. Feel isolated or lonely	□ Yes	□ No
c. Have clear goals for direction in life	□ Yes	□ No
d. Feel satisfied with your life	□ Yes	□ No

14. How many days of work have you missed in the past 4 weeks? _____

15. Review of Systems: Please check the box if currently or in the past any of the following symptoms have pertained to you. Do not include brief illnesses (colds, flus) from which you have recovered without complication.

- ☐ Cancer
- ☐ Unexplained weight loss
- ☐ Fever
- ☐ Nightsweats
- ☐ Excessive fatigue
- ☐ Chills

- ☐ Glasses/contacts
- ☐ Glaucoma
- ☐ Cataracts
- ☐ Vision loss
- ☐ Other eye problems

- ☐ Hearing loss
- ☐ Ringing in ears
- ☐ Dizziness
- ☐ Pain in ears, sinuses, throat, or teeth
- ☐ Prolonged hoarseness
- ☐ Frequent bloody nose
- ☐ Mouth sores
- ☐ Nasal discharge
- ☐ Snoring
- ☐ Allergic rhinitis

- ☐ Heart attack
- ☐ Chest pain/pressure
- ☐ High blood pressure
- ☐ Heart murmur
- ☐ Irregular/fast heartbeat
- ☐ Shortness of breath
- ☐ Swelling in legs
- ☐ Mitral Valve Prolapse
- ☐ Other heart problems
- ☐ Varicose veins
- ☐ High cholesterol
- ☐ Leg pain on walking
- ☐ Pacemaker

- ☐ Immune problems or frequent infections
- ☐ Food Sensitivities:

_____

_____

_____

- ☐ Cough
- ☐ Coughing up blood
- ☐ Asthma/wheezing
- ☐ Emphysema/chronic bronchitis
- ☐ Tuberculosis exposure

- ☐ Nausea/vomiting
- ☐ Diarrhea or constipation
- ☐ Blood or black tarry stool
- ☐ Change in bowel habits
- ☐ Pain in stomach/abdomen
- ☐ Heartburn/reflux/ulcer
- ☐ Difficulty swallowing
- ☐ Hepatitis/jaundice/liver problems
- ☐ Irritable bowel
- ☐ Other stomach/colon problems
- ☐ Diverticulosis/Diverticulitis
- ☐ Gas or bloating
- ☐ Frequent diarrhea

- ☐ Pain/difficulty with urination
- ☐ Blood in urine
- ☐ Kidney stone
- ☐ Leaking urine
- ☐ Other kidney/urinary problems

- ☐ Diabetes/blood sugar problems
- ☐ Thyroid problems/goiter
- ☐ Excess thirst/hunger/urination
- ☐ Infertility
- ☐ Excess heat/cold intolerance

- ☐ Back or neck pain
- ☐ Joint pain or swelling
- ☐ Morning stiffness < 1/2 hr.
- ☐ Morning stiffness > 1/2 hr.
- ☐ Gout

- ☐ Skin rash or changing mole
- ☐ Breast lump/nipple discharge
- ☐ Skin cancer/precancer
- ☐ Other skin/breast/nail/hair concern or change
- ☐ Rashes that come and go
- ☐ Acne
- ☐ Eczema or psoriasis

- ☐ Seizure
- ☐ Migraine/recurrent headache
- ☐ Concussion
- ☐ Stroke/mini-stroke
- ☐ Sudden loss of ability to see, speak, walk, move
- ☐ Numbness or weakness
- ☐ Passing out
- ☐ Tremor
- ☐ Other neurologic concerns
- ☐ Memory problems
- ☐ Coordination problems

- ☐ Depression, tearfulness
- ☐ Anxiety/panicky feelings
- ☐ Other emotional problems
- ☐ Sleep/concentration problems
- ☐ Any history of mental problems
- ☐ Disordered Eating

- ☐ Previous blood transfusion
- ☐ Abnormal bleeding/bruising
- ☐ Enlarged lymph nodes
- ☐ Anemia/other blood problems
- ☐ Blood clot in leg or lung

Other:

_____

_____

_____

_____

_____

_____

_____

15. Review of Systems:
(continued)

Males Only:

- ☐ Exposure to venereal disease
- ☐ Exposure to AIDS
- ☐ Discharge from the penis
- ☐ Lumps in the testicles
- ☐ Hernia in the groin
- ☐ Prostate problems
- ☐ Sexual difficulties

Females Only:

- ☐ Breast lumps
- ☐ Abnormal mammogram
- ☐ Abnormal menstrual bleeding
- ☐ Premenstrual Syndrome (PMS)
- ☐ Vaginal discharge
- ☐ Abnormal pap smear
- ☐ Abnormal pelvic pain
- ☐ Breast Implants
- ☐ Exposure to venereal disease
- ☐ Exposure to AIDS
- ☐ Sexual difficulties
- ☐ Menopausal
- ☐ Currently Pregnant

Number of pregnancies _____
Number of live births _____
Number of children living _____

16. Life Habits:

	None	Small	Medium	Large
Alcohol	☐	☐	☐	☐
Nicotine	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Sugared products	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Fun	☐	☐	☐	☐
Stress	☐	☐	☐	☐
Meditation	☐	☐	☐	☐
Prayer	☐	☐	☐	☐

17. Family History

Please list medical problems. Include diseases such as heart disease, high blood pressure, diabetes, cancer (which type), alcoholism, mental illness, high cholesterol, stroke, kidney disease, liver disease, bleeding disorders, depression, anxiety, chronic pain, arthritis, osteoporosis, or any other significant illness.

(A) denotes alive (D) denotes deceased

Your father's father _____

Your father's mother _____

Your mother's father _____

Your mother's mother _____

Your father _____

Your mother _____

Aunts or Uncles _____

Sibling _____

Sibling _____

Child _____

Child _____