**PATIENT INTAKE FORM**

**GENERAL INFORMATION**

Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ City\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ State\_\_\_\_\_\_ Zip\_\_\_\_\_\_\_\_\_

Primary Phone\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Email\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth\_\_\_\_\_\_\_\_\_\_\_\_\_ Gender: Male Female Marital Status\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any children? If so, how many?\_\_\_\_\_\_\_\_\_ Occupation\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about our clinic?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is your primary care physician?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Pharmacy (include address):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FUN FACTS**

Favorite Childhood memory:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Favorite Song: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Favorite beverage:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**FUNCTIONAL ASSESSMENT QUESTIONNAIRE**

Height (feet/inches):\_\_\_\_\_\_\_\_\_\_\_ Weight:\_\_\_\_\_\_\_\_\_\_\_ Desired weight (+/-5lbs):\_\_\_\_\_\_\_\_\_\_\_\_

Have you been under the care of a licensed healthcare professional in the last year? If yes, for what reasons? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your main health concerns at this time? Order by importance to you:



What would you like to get out of your consultation with Dr. Durland? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ALLERGIES**

Please list any allergies you have and the reaction: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any food allergies or sensitivies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If you had a magic wand and could erase three problems, what would you erase?



Please describe a time when you felt in complete health. Can you identify what prompted a change in your health/symptoms? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What makes you feel better? Worse? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**MEDICAL HISTORY**

**Diseases/Diagnosis/Conditions**

GASTROINTESTINAL

Past Current

Irritable Bowel Syndrome

Inflammatory Bowel Disease

* Crohn’s
* Ulcerative Colitis
* Gastritis or Peptic Ulcer
* GERD (reflux)
* Celiac Disease
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

CARDIOVASCULAR

Past Current

* Heart Attack
* Heart Disease
* Stroke
* Elevated Cholesterol
* Arrhythmia
* Hypertension

Past Current

* Rheumatic Fever
* Mitral Valve Prolapse
* Other\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

METABOLIC/ENDOCRINE

* Type 1 Diabetes
* Type 2 Diabetes
* Hypoglycemia
* Hypothyroidism
* Hyperthyroidism
* Eating Disorder
* Polycystic Ovarian Syndrome
* Weight Gain

CANCER

* Lung Cancer
* Breast Cancer
* Colon Cancer

Past Current

* Ovarian Cancer
* Prostate Cancer
* Skin Cancer

GENITAL & URINARY SYSTEMS

* Erectile Dysfunction
* Sexual Dysfunction
* Frequent UTI’s

MUSCULOSKELETAL/PAIN

* Osteoarthritis
* Fibromyalgia
* Chronic Pain

INFLAMMATORY/

AUTOIMMUNE

* Rheumatoid Arthritis
* Lupus SLE
* Herpes-Genital
* Food Allergies
* Environmental Allergies
* Latex Allergies
* Hepatitis

RESPIRATORY DISEASES

* Asthma
* Chronic Sinusitis
* Sleep Apnea

SKIN DISEASES

* Eczema
* Psoriasis
* Acne
* Melanoma
* Rashes

NEUROLOGIC/MOOD

Past Current

* Depression
* Anxiety
* Bipolar Disorder
* Schizophrenia
* Headaches
* Migraines
* ADD/ADHD

INJURIES

* Back Injury
* Neck Injury
* Broken Bones
* Head Injury
* Hand Injury
* Foot Injury
* Hip Injury

SURGERIES

* Appendectomy
* Gall Bladder
* Tonsillectomy
* Joint Replacement (Knee/Hip)
* Heart Surgery
* Pacemakers
* Hysterectomy
* Hernia
* Dental Surgery
* Other: \_\_\_\_\_\_\_\_\_\_\_\_

**WOMEN’S HEALTH INFO**

Age at First Period:\_\_\_\_\_ Menses Frequency: \_\_\_\_\_\_ Length:\_\_\_\_\_\_ Pain: Yes No

Last Menstrual Period: \_\_\_\_\_\_\_\_\_\_\_\_\_

Use of hormonal contraception such as: Birth Control Pills Patch Nuva Ring

How long have you/did you use hormonal contraception: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use contraception? Yes No If so, what method? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you sexually active? Yes No

Are you experiencing any of the following:

Hot Flashes Mood Swings Concentration/ Memory Problems Vaginal Dryness

Decreased Libido Joint Pains Headaches Weight Gain Loss of Control of Urine

Palpitations Use of Hormone Replacement Therapy (How long?) \_\_\_\_\_\_\_\_\_\_\_

**MEN’S HEALTH INFO**

Are you currently sexually active? Yes No

Have you had a PSA done? Yes No

Prostate Enlargement Prostate Infection Change in Libido Impotence

Difficulty Obtaining an Erection Difficulty Maintaining an Erection

Nocturia (urination at night). If yes, how many times during the night? \_\_\_\_\_\_\_\_\_\_\_

Urgency/Hesitancy/Change in Urinary Stream Loss of Control of Urine

|  |  |  |  |
| --- | --- | --- | --- |
| **CURRENT MEDICATIONS** | | | |
| **MEDICATION** | **DOSE** | **FREQUENCY** | **REASON FOR USE** |
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| --- | --- | --- | --- |
| **NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)** | | | |
| **SUPPLEMENT & BRAND** | **DOSE** | **FREQUENCY** | **REASON FOR USE** |
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**REVIEW OF SYSTEMS**

**Do you have any of the following symptoms or problems? (Check if the symptom/problem pertains to you)**

**General:** Fatigue Weight Gain

**Ears/ Nose/ Throat/ Sinuses:**  Hearing Loss Ringing in Ears Frequent Infections

Pain Frequent Canker Sores

**Heart/ Circulation:** Palpitations or Irregular Pulse Chest Discomfort Leg Swelling

**Lungs:** Shortness of Breath Wheezing Other

**Digestion/ Elimination:** Heartburn Nausea/Vomiting Abdominal Pain/Cramps Bloating

Excessive Belching Excessive Flatus Constipation Diarrhea

**Bladder/ Kidneys/ Urination:**  Frequent Infections Urgency Difficulty Urinating Leakage

Pain with Urination Blood in Urine

**Muscles/ Bones/ Joints:**  Muscle Pain Muscle Cramps or Spasms Tendonitis

Low Back Pain Joint Pain/Stiffness/Swelling Other

**Nervous System:**  Headaches Dizziness Balance Problems Weakness/numbness/tingling

Memory Problems Concentration problems

**Allergies/ Immune System:**  Seasonal or Other Allergies

**Hormonal/ Endocrine:**  Excessive Thirst Excessive Hunger Cold or Heat Intolerance

**Blood:**  Easy Bruising Abnormal Bleeding

**Skin:**  Rashes Eczema Other

**Psychiatric/ Psychological:**  Anxiety Panic attacks Depression Suicidal Thoughts

**SOCIAL HISTORY**

Do you smoke? Yes No If yes, how much? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How often do you use alcohol? Never Rarely 2-3x per Month 2-3x per Week Daily

Do you use any recreational drugs? Yes No If yes, what kind? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Yes No If yes, how often and what type? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How would you describe your energy level? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many meals do you generally eat per day? \_\_\_\_\_\_\_ Do you skip meals?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently on a special diet? Certain foods you avoid? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are your sources of protein? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**EMOTIONAL WELL-BEING**

How would you describe how you feel? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you feel significantly less vital than you did a year ago? Yes No

Are you happy? Yes No

Do you feel your life has meaning and purpose? Yes No

Do you believe stress is presently reducing the quality of your life? Yes No

Do you like the work you do? Yes No

Have you ever experienced major losses in your life? Yes No

Would you describe your experience as a child in your family as happy and secure? Yes No

**FAMILY MEDICAL HISTORY**

|  |  |
| --- | --- |
|  | **Please list your family members who previously experienced or are currently experiencing the following illnesses:** |
| **Arthritis** |  |
| **Alcoholism** |  |
| **Cancer: Breast** |  |
| **Cancer: Colon** |  |
| **Cancer: Prostate** |  |
| **Cancer: Other** |  |
| **Bipolar Disorder** |  |
| **Depression** |  |
| **Diabetes** |  |
| **Heart Disease** |  |
| **High blood pressure** |  |
| **Mental illness** |  |
| **Blood Disorder/ Sickle Cell** |  |
| **Other:** |  |

**SLEEP/REST**

Average number of hours you sleep per night:\_\_\_\_\_\_\_\_\_\_\_

Do you have trouble falling asleep? Yes No

Do you feel rested upon awakening? Yes No

Do you have problems with insomnia? Yes No

Do you snore? Yes No

Do you use sleeping aids? Yes No If yes, what do you use?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**STRESS/COPING**

Do you feel you have an excessive amount of stress in your life? Yes No

Do you feel you can easily handle the stress in your life? Yes No

Do you practice meditation or relaxation techniques? Yes No

If yes, how often and what type?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever been abused, a victim of a crime, or experience a significant trauma? Yes No

What major life decisions or changes are you facing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What do you feel are the most significant stressors in your life right now? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How do you manage stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My worst health habits are: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My best health habits are:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

My current self-care practices include: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**ROLES/RELATIONSHIP**

Marital status:\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have children? Yes No If yes, indicate how many & their ages/gender? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Who is living in household?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Resources for emotional support (check all that apply):

Spouse Family Friends Religious/Spiritual Pets Other:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your sex life? Yes No

**OVERALL WELLNESS**

Please rank your top three health concerns from the list below. (1 = most important health concern and 3 = least important health concern).

\_\_\_\_\_Weight Loss

\_\_\_\_\_Anxiety/depression

\_\_\_\_\_Feeling like yourself again

\_\_\_\_\_Fitness

\_\_\_\_\_Diet Planning

\_\_\_\_\_Counseling

\_\_\_\_\_Body pain

\_\_\_\_\_Skin care (acne, scarring, stretch marks, etc.)

\_\_\_\_\_Incontinence

\_\_\_\_\_Sexual dysfunction (ED included)

\_\_\_\_\_Fine lines/wrinkles

\_\_\_\_\_Supplements

\_\_\_\_\_Thyroid

\_\_\_\_\_Adrenals

\_\_\_\_\_Diabetes

\_\_\_\_\_Stomach issues/bloating

\_\_\_\_\_Hair loss

\_\_\_\_\_Gut health