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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:

1.
2.
3.
4.

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

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ALLERGIES

Please list any allergies you have and the reaction:

____

____

Do you have any food allergies or sensitivities?

____

____

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

1.
2.
3.

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

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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**

NUTRITIONAL SUPPLEMENTS (VITAMINS/MINERALS/HERBS/HOMEOPATHY)			
SUPPLEMENT & BRAND	**DOSE**	**FREQUENCY**	**REASON FOR USE**

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