



INITIAL PATIENT FORM

Name _____ Date _____

How did you find out about us? _____

What is/are the primary problem(s) you are having? _____

Tell us about your living situation: _____

Occupation _____

Education _____

Have there been any recent changes in the family? _____ Yes _____ No

If yes, please explain: _____

Medications List all medications (including over the counter meds and vitamins)

Medication	Dose	Reason
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

Do you have any medication allergies? _____ Yes _____ No

If yes, list the medications and describe your reactions: _____

Do you have any food or environmental allergies? _____ Yes _____ No

If yes, list them and describe your reactions: _____



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Are you ___ Lactose Intolerant? ___ Glucose Intolerant?

Have you ever been hospitalized? ___ Yes ___ No

If yes, please list dates and reason for admission: _____

Current Primary Care MD _____ Specialist _____ Dentist _____

Date of last visit _____ Date of last physical _____

Do you wear a seat belt? ___ Yes ___ No

Do you drive? ___ Yes ___ No

Are you sexually active? ___ Yes ___ No

Do you use contraception? ___ Yes ___ No

If yes, what type? _____

Have you had any major injuries? ___ Yes ___ No

If yes, when and what happened? _____

Have you had any traumatic events? ___ Yes ___ No

If yes, what happened? _____

Have you ever been emotionally, physically, or sexually abused? ___ Yes ___ No

If yes, please describe: _____

Do you drink alcohol? ___ Yes ___ No If yes, how much? ___ Drinks/week

Do you smoke? ___ Yes ___ No If yes, how much? ___ Cigarettes /day

Do you use any other substance(s)? If so, what _____

Approximate number of hours per week spent in physical activity, sports, gym, etc.

- None 1-4 hrs 5-7 hrs 8-12 hrs >12 hrs



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Have you had any of the following illnesses or problems?

- | | | |
|--|---|---|
| <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Rheumatic Fever |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> TB | <input type="checkbox"/> Cancer | <input type="checkbox"/> Kidney/Urinary Problems |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Anemia | <input type="checkbox"/> Seasonal/Environmental allergies |
| <input type="checkbox"/> Joint Pain | <input type="checkbox"/> Menstrual Problems | <input type="checkbox"/> Stomach/Intestine Problem |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Weight loss |
| <input type="checkbox"/> Neck/Back Pain | <input type="checkbox"/> Fainting | <input type="checkbox"/> Cold all the time |
| <input type="checkbox"/> Heart Murmurs | <input type="checkbox"/> Hypertension | <input type="checkbox"/> Eye Problems |
| <input type="checkbox"/> Clotting Problems | <input type="checkbox"/> Dizziness | <input type="checkbox"/> _____ |

If you checked any item above, please explain, date, type and length of illness: _____

Nutrition Assessment

Please check any food/fluid/weight struggles that you are currently experiencing:

- | | | |
|-----------------------------|-----------------------|------------------------------|
| • Calorie restriction | • Excessive exercise | • Body image distress |
| • Binge eating | • Compulsive exercise | • Significant weight changes |
| • Dieting | • Diet pills | • Frequently weighing self |
| • Rigid food rules/rituals | • Laxatives (abuse) | • Low weight |
| • Lack of food variety | • Diuretics (abuse) | • Overweight |
| • Chewing and spitting | • Purging (vomiting) | • Constipation |
| • Fluid restriction | • Regurgitation | • Diarrhea |
| • Fluid loading | • Hiding food | • Reflux |
| • Excessive caffeine intake | • Calorie counting | • Involuntary vomiting |
| • Excessive alcohol intake | • Other _____ | • Other _____ |

Describe in further detail any concerns checked above (frequency, volume, etc):



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To the best of your ability, please describe what a typical day of food consumption is like for you during the week and weekend. Include eating times and places, with whom, beverages and condiments consumed, and exercise (if applicable).

Weekday

Weekend

Immunizations:

Last tetanus booster _____ Date _____

TB Test _____ Date _____ Result _____

Hepatitis A Series _____ Yes _____ No _____ Don't know

Hepatitis B Series _____ Yes _____ No _____ Don't know

HPV _____ Yes _____ No _____ Don't know



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Family History

Have any members of your immediate natural family, alive, or dead, had any of the following conditions? If yes, please state the age the condition was diagnosed and the relationship of this person to you.

Condition		Relationship to you
Allergies/Asthma	• Yes • No	_____
Alcoholism/Drug Problems	• Yes • No	_____
Arthritis	• Yes • No	_____
Cancer	• Yes • No	_____
Diabetes	• Yes • No	_____
Gastrointestinal Illness	• Yes • No	_____
Hormone Problems	• Yes • No	_____
Heart Attack/Stroke before age 55	• Yes • No	_____
High Cholesterol	• Yes • No	_____
Kidney/Liver/Lung Disease	• Yes • No	_____
Developmental Delays/Birth Defects	• Yes • No	_____
Mental Illness	• Yes • No	_____
Migraines	• Yes • No	_____
Eating Disorder/Obesity	• Yes • No	_____
Osteoporosis	• Yes • No	_____
Seizure Disorder	• Yes • No	_____
Suicide	• Yes • No	_____
Thyroid Disorder	• Yes • No	_____

Are there any other things that you would like us to know that my help in your care?

Patient Signature _____ Date _____



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PAIN ASSESSMENT FORM												
Do you have pain? Yes or No	If “Yes” , please answer the follow pain questions . . .											
Where is your pain located?												
What type of pain?												
How much does your pain hurt? (What is your pain intensity?) <i>(Please circle number)</i>	No hurt	Hurts a little <i>(Mild & annoying)</i>		Hurts more than a little <i>(Nagging, uncomfortable, troublesome)</i>		Hurts even more <i>(Miserable, distressing)</i>		Hurts a whole lot <i>(Intense, dreadful, horrible)</i>		Hurts Worse <i>(Worst pain possible, unbearable)</i>		
	0	1	2	3	4	5	6	7	8	9	10	
How long have you had this pain?												
What causes you to have pain or for the pain to increase?												
How does your pain affect your functioning or quality of life? <i>(Please circle number)</i>		Does not limit activities		Can do most activities with rest period		Unable to do some activities		Unable to do most activities		Unable to do any activities		
	0	1	2	3	4	5	6	7	8	9	10	
Do you get treatment for your pain? No Yes or												
What is your pain treatment and who prescribes it?												
How much relief do you get from your pain treatment? <i>(Please circle number)</i>	No Relief 1			Mild Relief 2			Moderate Relief 3			Complete Relief 4		