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Thank you for choosing Intentional Health Clinic to be part of your healthcare. We ask for your cooperation and patience as you complete this health history questionnaire. Integrative healthcare is enhanced dramatically when the provider has a complete picture of the patient physically, mentally, emotionally, and spiritually. If something in the form is hard to recall, we only ask you to do your best. The more information you provide, the better your practitioner will be able to serve your health needs. Please allow 15-20 minutes to complete the entire form before your first visit. You may e-mail filled out form to your provider or bring it with you to the appointment. We would prefer completion of the form and submission via e-mail at least 1 day before your appointment to have a more directed and efficient visit with you.

New Patient Intake

Name: _____ **Date**: _____

Age: _____ **DOB**: _____

Gender at birth: Male / Female **Identifying Gender**: Male/Female/Other

Preferred Pronoun: He/She/They

If patient is under 18 years of age, please list guardian and their relationship to patient:

_____

Telephone: (h) _____ (c) _____

Address: _____

City: _____ **State**: _____ **Zip**: _____

Email: _____

Emergency Contact: _____ **Relationship**: _____

Telephone: (h) _____ (c) _____

Name of primary care physician: _____

HEALTH CONCERNS

Please list your most important physical, emotional, or mental health concerns. Indicate which is/are of the most immediate concern to you.

1. _____
2. _____
3. _____
4. _____
5. _____

HEALTH GOALS

Please list your long-term health goals, ranking the most important first.

1. _____
2. _____
3. _____

How do you rate your overall health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

What are your expectations for your first visit?

HEALTH HISTORY

- Do you have a PCP (primary care physician) _____ Name: _____
- When did you last receive medical care? _____
- Where (Clinic)? _____
- By whom (Practitioner)? _____

Please list the following:

Surgeries/Date	Hospitalizations/Date

HEALTH STUDIES/LABS

- When was your last blood test? _____
- Abnormal values? _____
- What is your blood type? _____
- Any other recent tests? _____

IMMUNIZATION HISTORY: Please indicate if you have received any of the following vaccines

Hep A	Y/ N	Tetanus (DtAP/TdAP)	Y/ N	Polio	Y/ N
Hep B	Y/ N	Flu (seasonal)	Y/ N	Shingles	Y/ N
HPV	Y/ N	MMR(Measles/Mumps/Rubella)	Y/ N	Rotovirus	Y/ N
Chicken pox	Y/ N	Pneumococcal	Y/ N	HiB	Y/ N
Smallpox	Y/ N	Meningococcal	Y/ N	TB	Y/ N

HISTORY- PERSONAL

Please list significant illness or diseases you have been diagnosed with in the past (ie. chicken pox, asthma, etc.) and the approximate date you were diagnosed.

1. _____
2. _____
3. _____
4. _____
5. _____

MEDICATIONS & ALLERGIES

PRESCRIBED & NATURAL MEDICINES Please list all prescribed drugs, vitamins, herbs, and others you are taking at present, with dosage.	**ALLERGIES/INTOLERANCES** Please list any food, medication, or environmental allergies and your reaction to them.

HISTORY- FAMILY

Please list ages and check any major health problems. If deceased, please list what they died from (ie. cancer, old age), and at what age

	Living/ Deceased	Age	Cancer	Diabetes	High Blood Pressure	Thyroid Disease	Auto-Immune Disease	Please Specify or Indicate Others
Immediate Family								
Mother	L/ D							
Father	L/ D							
Sisters	L/ D							
Brothers	L/ D							
Mother's Side								
Grandmother	L/ D							
Grandfather	L/ D							
Father's Side								
Grandmother	L/ D							
Grandfather	L/ D							

SOCIAL HISTORY

Occupation: _____

Are you: ____ Married ____ Separated ____ Divorced ____ Single ____ Widowed ____ Partnered

With whom do you live? ____ Spouse ____ Parents ____ Relatives ____ Friends ____ Alone ____Other

Do you have the support of family and friends to make positive changes in your life?

_____

Have you traveled outside the US?

- Where & when?

  _____

Do you have a religious or spiritual practice? _____

Please rate your current level of satisfaction for the following: (1=very dissatisfied; 5= very satisfied)

Work: 1—2—3—4—5	Family: 1—2—3—4—5
Social: 1—2—3—4—5	Financial: 1—2—3—4—5

ENVIRONMENTAL HISTORY

Check any of the following you routinely use at home or at work.

____ Gas heat ____ Oil heat ____ Electric heat ____ Wood stove ____ Air conditioning ____ Electric blanket

Water: ____ Distilled ____ Filtered ____ Spring ____ Well ____ Tap/City

Are you exposed to environmental or chemical hazards at home or work? If yes, please specify.

DIET

Number of meals eaten per day: 1 2 3 More than 3

How is your appetite? ____ Excellent/Love food! ____ Good

____ Eat food for sustenance ____ Go hours without eating

Do you follow any specific diet (vegan, vegetarian, etc.,)? If yes, please specify:

List the primary foods in your diet:

List the foods excluded from your diet:

List any of the following (and relative amounts) eaten regularly by you:

Coffee, caffeinated teas, processed foods, preservatives, refined foods, alcohol

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List any of the foods you crave, regardless of their nutritional value (including sweets, salty,

sour, bread, rich/fatty foods, etc.) _____

Are you satisfied with your diet as it is now? __Y / N_____ If not, why not? _____

EXERCISE

Hours spent in physical activity per week _____ Type of exercise _____

HOBBIES_____

SYSTEMS REVIEW (Please check symptoms that you have now or have had in the past)

GENERAL/CONSTITUTIONAL

Height _____
Weight _____
Maximum weight _____
When? _____
Last physical? _____
Hours of sleep per night_____

- ☐ Trouble falling asleep
- ☐ Trouble staying asleep
- ☐ Night sweats

SKIN

- ☐ Rashes
- ☐ Itching
- ☐ Color change
- ☐ Lumps
- ☐ Varicose veins
- ☐ Dry skin

HEAD

- ☐ Headaches
- ☐ Head injury
- ☐ Dizziness/vertigo
- ☐ Hair loss
- ☐ Jaw pain

EARS

- ☐ Difficulty hearing
- ☐ Ringing
- ☐ Earache

EYES

- ☐ Impaired vision
- ☐ Eye pain
- ☐ Tearing/dryness
- ☐ Itchy eyes
- ☐ Double vision
- ☐ Cataracts
- ☐ Bulging eyes
- ☐ Blurriness

NOSE/SINUS

- ☐ Frequent colds
- ☐ Nose bleeds
- ☐ Stuffiness
- ☐ Sinus problems
- ☐ Loss of smell

MOUTH & THROAT

- ☐ Frequent sore throat
- ☐ Gum problems
- ☐ Hoarseness
- ☐ Difficulty swallowing

NECK

- ☐ Lumps
- ☐ Swollen glands
- ☐ Goiter
- ☐ Stiff or painful neck

CARDIOVASCULAR

- ☐ Heart disease
- ☐ Murmurs
- ☐ Chest pain
- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Swelling in ankles, feet, or hands
- ☐ Palpitations
- ☐ Irregular heart beat
- ☐ Shortness of breath

RESPIRATORY

- ☐ Cough
- ☐ Coughing blood
- ☐ Congestion
- ☐ Wheezing
- ☐ Shortness of breath
- ☐ Painful Breathing
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Asthma
- ☐ Emphysema
- ☐ Tuberculosis

BLOOD

- ☐ Easy bruising
- ☐ Clotting disorders
- ☐ Slow wound healing
- ☐ Anemia

MUSCULOSKELETAL

- ☐ Joint pain
- ☐ Joint stiffness/swelling
- ☐ Arthritis
- ☐ Muscle pain or cramps
- ☐ Weakness
- ☐ Back pain
- ☐ Cold extremities
- ☐ Difficulty walking

NEUROLOGICAL

- ☐ Fainting
- ☐ Seizures
- ☐ Numbness/Tingling
- ☐ Tremors

- ☐ Paralysis

PSYCHOCOLOGICAL

- ☐ Depression
- ☐ Anxiety
- ☐ Nervousness
- ☐ Insomnia
- ☐ Hallucinations
- ☐ Mood swings
- ☐ Memory loss
- ☐ Confusion

ENDOCRINE

- ☐ Hypothyroid
- ☐ Hyperthyroid
- ☐ Cold/Heat intolerance
- ☐ Low blood sugar
- ☐ Diabetes
- ☐ Excessive hunger/thirst

URINARY

- ☐ Painful urination
- ☐ Increased frequency
- ☐ Frequency at night
- ☐ Urgency
- ☐ Frequent infections
- ☐ Kidney stones

GASTROINTESTINAL

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas/Belching
- ☐ Heart burn
- ☐ Indigestion
- ☐ Blood in stool
- ☐ Blood in vomit
- ☐ Abnormal cramping
- ☐ Hemorrhoids
- ☐ Hernias
- ☐ Gallbladder problems
- ☐ Liver problems
- ☐ Change in bowel movements
- ☐ Loss of appetite

MALE REPRODUCTIVE

Currently sexually active?
☐Yes ☐No
Have you been in the past?
☐Yes ☐No
Type of contraception used
_____
Have you had a prostate exam?
☐Yes ☐No
If Yes, when? _____
Sexual desire, please rate:
1—2—3—4—5—6—7—8—9—10
(1: very unsatisfied → 10: very satisfied)

- ☐ Erectile dysfunction
- ☐ STDs
- ☐ Penile infections
- ☐ Split urine stream
- ☐ Abnormal discharge
- ☐ Redness
- ☐ Prostatitis
- ☐ Blood in semen
- ☐ Painful ejaculation
- ☐ Lump in testicle
- ☐ Painful testicles

FEMALE REPRODUCTIVE

Currently sexually active?
☐Yes ☐No
Have you been in the past?
☐Yes ☐No
Type of contraception used
_____
Sexual desire, please rate:
1—2—3—4—5—6—7—8—9—10
(1: very unsatisfied → 10: very satisfied)

Do you have a period?
☐Yes ☐No
Age of first period _____
Period is/was every _____
days, lasting _____ days
Is/was period regular?
☐Yes ☐No
Bleeding between cycles
☐Yes ☐No
Quality of blood (dark, clots)
_____
Flow on first day (#pads/or tampons per day) _____
(heavy, light) _____

- ☐ PMS

Date of last period
_____
Date when menopause began
_____
Date of last PAP _____
Abnormal PAP?
☐Yes ☐No
Number of:

- Pregnancies _____
- Births _____
- Miscarriages _____
  Abortions_____

- ☐ Difficulty conceiving
- ☐ Abnormal discharge
- ☐ Redness
- ☐ Itching
- ☐ Sense of pelvic fullness
- ☐ Breast pain/tenderness
- ☐ Lumps
- ☐ Infection
- ☐ Nipple discharge

Date of last mammogram:
_____

Are you currently pregnant?
☐Yes ☐No