New Patient Intake Form

***Please make notes on an additional page if there is not enough space.*

Name: _____ Date:_____

Date of Birth:_____

Address_____

Contact phone number:_____ May we leave messages at this number: Y N

Emergency contact name:_____ Emergency contact number:_____

Preferred pharmacy (name/address/number):_____

Primary care provider (name, location):_____

Insurance (plan, group number, member ID):_____

Please list physicians or other practitioners you see (or have seen in last 3 years):

Name	Address and/or phone	Specialty/condition being treated

What is the reason for your visit (please check all that apply)?

- Generalized pain or fibromyalgia
- Fatigue
- Other_____

How did you learn about this practice?_____

What are your primary goals in obtaining care?

1.
2.
3.

Please provide a brief summary of your illness:

Please list treatments that have been tried, when, and how effective they were (current medications will be listed later, but you can mention medications here that are pertinent to your reason for visit):

Current medical problems

List ongoing/current medical issues (eg, diabetes, high blood pressure, hypothyroidism):

Past medical history

List past major illnesses or injuries, hospitalizations, chronic diseases, etc. Please be sure to note if you've had the following: asthma, migraine, or unusually long or frequent illnesses:

Problem	Date	Problem	Date

Past surgical history

List surgeries and major procedures:

Surgery	Date	Surgery	Date

(Please list additional medical problems or surgeries on a separate page.)

Gynecologic/Obstetrical history

Women:

	Date(s)		Date(s)
Vaginal births		Miscarriage/Still birth	
C-sections		Induced abortion	
Abnormal PAP		Other Gyn	

Medications

List current medications and doses (including supplements, over-the-counter, and as needed medications):

Medication name	Dose	Frequency (daily, twice a day, as needed, etc.?)	Indication (what do you take it for?)

(Please list any additional medications and supplements on a separate page.)

Allergies

Please list allergies (or other adverse reactions) to medications, foods, and other substances:

Medication or other trigger	Reaction	When does/did this occur?

Review of systems

Note symptoms *occurring within the last few months* unless question asks about history. However, if there is anything else pertinent in your history to note, please write in the notes section:

Symptom	*Severity* 0: never/rare/insignificant 1: occasional/mild 2: moderate 3: frequent and/or severe	*Additional notes*
Constitutional		
Fever	0 1 2 3	
Chills	0 1 2 3	
Sweats (Night? Day?)	0 1 2 3	
Weight gain	0 1 2 3	
Weight loss	0 1 2 3	
Fatigue	0 1 2 3	
Other?	0 1 2 3	
Eye		
Blurred vision	0 1 2 3	
Eye pain	0 1 2 3	
Eye redness	0 1 2 3	
Dry eyes	0 1 2 3	
Visual loss	0 1 2 3	
Double vision	0 1 2 3	
Head, ear, nose, throat		
Ear pain or congestion	0 1 2 3	
Ringing in ears	0 1 2 3	
Congestion in nose	0 1 2 3	
Sinus pressure or pain	0 1 2 3	
Nosebleeds	0 1 2 3	
Sore throats	0 1 2 3	
Dry mouth	0 1 2 3	
Cold sores (history of)	0 1 2 3	

Cardiovascular		
Chest pain	0 1 2 3	
Heart murmur	0 1 2 3	
Palpitations (heart thumping/racing)	0 1 2 3	
Dizziness with standing	0 1 2 3	
Shortness of breath when lying down	0 1 2 3	
Swelling in legs	0 1 2 3	
Raynaud's phenomenon (eg, tips of fingers and/or toes turn white)	0 1 2 3	
Respiratory		
Shortness of breath (when?)	0 1 2 3	
Wheezing	0 1 2 3	
Cough	0 1 2 3	
Gastrointestinal		
Abdominal pain (where?)	0 1 2 3	
Indigestion/heart burn	0 1 2 3	
Nausea or vomiting (which?)	0 1 2 3	
Constipation	0 1 2 3	
Diarrhea	0 1 2 3	
If diarrhea or constipation:		
Do you experience pain in your abdomen along with changes in bowel habits?		
Does having a bowel movement relieve or alter your pain?		
Has pain with bowel changes occurred at least one day a week on average for the last 3 months?		
Genitourinary		
Pain or burning with urination	0 1 2 3	
Frequent urination	0 1 2 3	
Urinating at night: How many times do you wake up in the middle of sleep		

to use restroom?		
Excessive urination	0 1 2 3	
Difficulty emptying bladder	0 1 2 3	
Urinary incontinence (losing urine)	0 1 2 3	
Decreased sexual desire	0 1 2 3	
Pain with intercourse	0 1 2 3	
Sexually transmitted disease history	0 1 2 3	
Fertility issues	0 1 2 3	
Men: erectile dysfunction	0 1 2 3	
Women		
- Heavy vaginal discharge	0 1 2 3	
- Vaginal itching/dryness	0 1 2 3	
- Last menstrual period:	Date:	
- Painful menstrual period	0 1 2 3	
- Irregular periods	0 1 2 3	
Musculoskeletal		
Generalized or all over pain	0 1 2 3	
Pain in joints		
- Knees	0 1 2 3	
- Hands	0 1 2 3	
- Wrists	0 1 2 3	
- Shoulders	0 1 2 3	
- Hip	0 1 2 3	
- Other joints (where?)	0 1 2 3	
Joint swelling	0 1 2 3	
Joint redness	0 1 2 3	
Stiffness	0 1 2 3	
Muscle pain	0 1 2 3	
Back pain		
- Neck pain	0 1 2 3	

- Upper back pain	0 1 2 3	
- Lower back pain	0 1 2 3	
Excessive joint flexibility	0 1 2 3	
Neurologic		
Abnormal walking/falls	0 1 2 3	
Headache	0 1 2 3	
History of seizures	No Yes (1 2 3)	
History of TIA or stroke	No Yes (what happened?)	
Fainting/loss of consciousness	0 1 2 3	
Muscle twitching	0 1 2 3	
Muscle weakness	0 1 2 3	
Numbness or tingling	0 1 2 3	
Burning or lightning-like pain	0 1 2 3	
Sensitivity to light or sound	0 1 2 3	
Sleep		
- Difficulty going to sleep	0 1 2 3	
- Difficulty staying asleep	0 1 2 3	
- Drowsiness during the day	0 1 2 3	
- Snoring (according to observer)	0 1 2 3	
- Stop breathing while sleeping	0 1 2 3	
Skin/breast		
Itching	0 1 2 3	
Rash	0 1 2 3	
Skin pigment changes	0 1 2 3	
New or changing moles	0 1 2 3	
Breast pain	0 1 2 3	
Breast lumps	0 1 2 3	
Nipple discharge (describe if so)	0 1 2 3	
Hematopoetic/lymphatic		
History of clots	0 1 2 3	

Swollen or tender glands (eg, neck, groin, or armpits)	0 1 2 3	
Easy bruising	0 1 2 3	
Easy/excessive bleeding	0 1 2 3	
Anemia	0 1 2 3	
Endocrine		
Hot flashes	0 1 2 3	
Heat intolerance (hot bothers you)	0 1 2 3	
Cold intolerance	0 1 2 3	
Excessive urination	0 1 2 3	
Excessive hunger	0 1 2 3	
Excessive thirst	0 1 2 3	
Allergic/Immunologic		
Pollen allergies	0 1 2 3	
Other sensitivities/allergies	0 1 2 3	What?
Psychiatric		
Anxiety	0 1 2 3	
Depression	0 1 2 3	
Thoughts of hurting self or others	0 1 2 3	
Mood swing or feeling unnaturally high	0 1 2 3	
Memory loss	0 1 2 3	
Difficulty concentrating	0 1 2 3	
Difficulty thinking through things	0 1 2 3	

Environmental/Exposures

Exposure		**Description**
Live(d) in water-damaged, moldy, or musty building?	Y N	Describe circumstances (when, where, what was the issue?)
Travel outside the US?	Y N	When/where?
Food poisoning history?	Y N	Describe?

Social History

Any history of		
- Alcohol intake	Y N	If currently using, avg #drinks/day:_____ Max drinks/day (last 6 mo):_____
- Tobacco use (including >10 cigs ever)	Y N	If so, current use? Y N #Years used:___ Type (eg cig, e-cig, chewing):_____ Packs per day/quantity:__
- Illicit drug use (last 5 years)	Y N	Describe:
- IV drug use (ever)	Y N	
- Tattoos done in nonprofessional setting	Y N	
Current Occupation:		
Hours/week:		
Describe social/family support:		
History of abuse:		

Family history

Please note if you have had close relative(s) (eg, parent, sibling, grandparent, aunt, uncle) with the following:

Condition		Relationship	Condition		Relationship
Chronic fatigue syndrome	Y N		Rheumatoid arthritis, lupus, other autoimmune illness:	Y N	
Fibromyalgia	Y N		Thyroid disease	Y N	
Cancer (type_____)	Y N		Multiple sclerosis	Y N	
Heart disease	Y N		Diabetes	Y N	
Stroke	Y N		Other:_____		
Immune deficiency	Y N		Other:_____		

Diet

Please list:

Typical breakfast foods:

Typical lunch foods:

Typical supper foods:

Typical snacks:

Exercise

Please list what you do in a typical week for exercise (or physical activity if you do not normally exercise):