

# Family Tree Medicine

## New Patient Intake Form

Please fill this out entirely and bring it with you to your first office visit.

Name \_\_\_\_\_ Date \_\_\_\_\_ SSN \_\_\_\_\_  
Address \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_  
Phone (H) \_\_\_\_\_ (W) \_\_\_\_\_ Email \_\_\_\_\_  
Date of Birth \_\_\_\_\_ Age \_\_\_\_\_ Sex \_\_\_\_\_ Occupation \_\_\_\_\_  
Employer \_\_\_\_\_ Hrs per Week \_\_\_\_\_ Live alone?   
How did you hear about Family Tree Medicine? \_\_\_\_\_  
Emergency Contact \_\_\_\_\_ Phone \_\_\_\_\_

Amanda or Jenny will need to reach you by phone from time to time. In order to ensure your privacy, please select the place you would like messages left for you.

- Home message machine
- With family members
- At work
- Never leave messages

### What are your primary health concerns?

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### When was the last time you received medical care and why?

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### General Information:

Height \_\_\_\_\_ Weight \_\_\_\_\_  
Weight 1 yr ago \_\_\_\_\_  
Maximum weight \_\_\_\_\_ When \_\_\_\_\_  
When during the day is your energy and alertness best? \_\_\_\_\_ Worst? \_\_\_\_\_ Blood type \_\_\_\_\_  
Primary interests and hobbies \_\_\_\_\_  
Primary form of exercise, if any \_\_\_\_\_  
How often \_\_\_\_\_

### Are you aware of having allergies to any of the following? If so, describe your reaction to each one:

Drugs: \_\_\_\_\_  
Foods: \_\_\_\_\_  
Chemicals/Perfumes: \_\_\_\_\_  
Animals: \_\_\_\_\_

**Please let us know if you or any family member has these conditions (or had in the past). Check all boxes that apply and indicate whom the condition applies to.**

<input type="checkbox"/> Anemia _____	<input type="checkbox"/> Multiple Sclerosis _____
<input type="checkbox"/> Cancer _____	<input type="checkbox"/> Stroke _____
<input type="checkbox"/> Heart Disease _____	<input type="checkbox"/> Asthma _____
<input type="checkbox"/> Mental Illness _____	<input type="checkbox"/> Epilepsy _____
<input type="checkbox"/> Alzheimer's _____	<input type="checkbox"/> Kidney Disease _____
<input type="checkbox"/> Arthritis _____	<input type="checkbox"/> Parkinson's _____
<input type="checkbox"/> Diabetes _____	<input type="checkbox"/> Other (please list) _____
<input type="checkbox"/> Hypertension _____	_____

**Which immunizations have you had. If you don't know if you've had one, place a question mark beside it.**

Diphtheria       Measles/Mumps/Rubella       Meningitis       Polio  
 Tetanus       Chickenpox       Hepatitis A/B/C       Pertussis       Flu  
 Other: \_\_\_\_\_

**Which diagnostic studies have you had in the past year?**

Electrocardiogram (EKG)     X-Ray       Bone Density Scan (DEXA)  
 CT Scan     Electroencephalogram (EEG)     Mammogram     MRI  
 Other: \_\_\_\_\_

**Which medications, either by prescription or over-the-counter, are you taking or have you taken in the past 6 months?**

Laxatives       Pain Relievers       H2 Blockers/Ulcer Medication  
 Antacids       Cortisone/Prednisone       Appetite Suppressants  
 Antidepressants       Antibiotics       Tranquilizers  
 Thyroid medication     Cholesterol-lowering medication  
 Sleeping medication     Other \_\_\_\_\_

**Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. Note: Please bring each of these with you to your first office visit.**

1) \_\_\_\_\_  
 2) \_\_\_\_\_  
 3) \_\_\_\_\_  
 4) \_\_\_\_\_  
 5) \_\_\_\_\_  
 6) \_\_\_\_\_

Please inform us of any medical concerns you may have not covered by this **intake form**.

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**Please circle the appropriate response.(Y=yes,N=no)**

- Y N Get 6-8 hours of sleep nightly?
- Y N Sleep Well?
- Y N Awaken Rested?
- Y N Watch TV? Hours daily \_\_\_\_
- Y N Read? Hours daily \_\_\_\_
- Y N Eat 3 meals daily?
- Y N In a supportive relationship ?
- Y N Eat out more than 3 times weekly?
- Y N History of abuse
- Y N Go on diets more than twice yearly?
- Y N Suffered recent (past 3 years) major life trauma
- Y N Drink tea?
- Y N Use recreational drugs
- Y N Drink coffee?
- Y N Treated for drug/alcohol dependence
- Y N Drink soda/cola?
- Y N Use products with Nutrasweet or Splenda?
- Y N Drink alcohol?
- Y N Add sugar/salt to food?
- Y N Use tobacco? If so, how many packs daily: \_\_\_\_ How many years: \_\_\_\_
- Y N Enjoy your work?
- Y N Spend time outside?
- Y N Take vacations?

**Review of Systems**

In this section, check the box if you have the symptom currently or w/in 6months.

**Mental/Emotional Neurological**

- Treated for depression
- Seizures
- Mood swings
- Muscle weakness
- Considered/Attempted suicide
- Loss of memory
- Poor concentration
- Vertigo/dizziness
- Depression
- Paralysis
- Anxiety or nervousness
- Numbness or tingling
- Tension
- Easily stressed
- Memory problems

**Endocrine**

- Hair loss
- Brittle nails
- Excessive thirst
- General fatigue
- Fatigue after meals
- Heat intolerance
- Cold intolerance
- Seasonal Depression

**Nose/Sinuses/Head/Eyes/Ears**

- Earaches
- Itching inside or outside
- Ringing
- Impaired hearing
- Frequent popping
- Frequent head colds
- Stuffiness
- Sinus pain
- Nose bleeds
- Headaches
- Hay fever
- Migraines
- Loss of smell
- Head injury
- Jaw pain/TMJ
- Spots in vision
- Blurriness
- Color blindness
- Double vision
- Cataracts
- Eye pain/strain
- Glaucoma
- Uncomfortable tearing or dryness

**Immune**

- Chronic fatigue syndrome
- Swollen glands
- Reaction to vaccines
- Ongoing infections
- Slow wound healing
- Colds/flu more than once yearly

**Mouth and Throat**

- Frequent sore throat
- Teeth grinding
- Gum bleeding/pain/disease
- Dental cavities
- Copious saliva
- Sore tongue/lips
- Jaw clicks

**Respiratory**

- Cough
- Spitting of blood
- Asthma
- Pneumonia
- Emphysema
- Pain on breathing
- Hoarseness
- Shortness of breath daily
- Lung congestion/sputum
- Wheezing
- Bronchitis
- Difficulty breathing
- Shortness of breath at night
- Shortness of breath lying down
- Difficult taking a full deep breath
- Pleurisy

**Neck**

- Lumps
- Pain or stiffness
- Goiter/enlargement in front of throat

**Skin**

- Rashes
- Acne, boils
- Color changes
- Lumps
- Eczema
- Hives
- Generalized itching

**Cardiovascular**

- Heart disease
- High blood pressure
- Low blood pressure
- Blood clots
- Phlebitis
- Rheumatic fever
- Ankle swelling
- Night sweats
- Angina/chest pain
- Heart murmurs
- Fainting
- Heart palpitations/fluttering

**Urinary**

- Pain with urination
- Frequent infections
- Unable to hold urine
- Kidney stones
- Splitting of stream
- Frequency at night; If so, how often do you wake to urinate each night \_\_\_\_

**Intestinal**

- Trouble swallowing
- Change in thirst
- Change in appetite
- Nausea/vomiting
- Burning pain in stomach
- Jaundice
- Gallbladder disease
- Liver disease
- Hemorrhoids
- Heartburn
- Abdominal pain or cramps
- Excessive belching or excess gas
- Constipation
- Diarrhea

- Black stools
- Blood in stools
- Bowel movement (BM) daily? How often \_\_\_\_\_

**Musculoskeletal**

- Joint pain or stiffness
- Broken bones
- Muscle spasms or cramps
- Arthritis
- Weakness
- Sciatica

**Blood/Peripheral Vascular**

- Easy bleeding/bruising
- Deep leg pain
- Varicose veins
- Anemia
- Cold hands
- Cold feet

**Female Reproduction/Breasts**

(questions apply to lifetime)  
 Age at first menses (first period) \_\_\_\_  
 Age of last menses (if menopausal) \_\_\_\_  
 Usual length of cycle (blood flow to next blood flow): \_\_\_\_  
 Duration of menstruation (days of bleeding) \_\_\_\_

- Irregular cycles
- Painful menses
- Heavy flow
- Light flow
- Clotting
- Discharge
- PMS
- Menopausal
- Endometriosis symptoms
- Ovarian cysts
- Sexually active
- Pain during intercourse

- Difficulty conceiving
- Bleeding/spotting between periods
- Cervical dysplasia
- Sexual difficulties
- Gonorrhea
- Genital herpes
- Chlamydia
- Condyloma/genital warts
- Syphilis
- Date of last annual exam/Pap \_\_\_\_\_

- Use of birth control; if so, what type \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_
- live births \_\_\_\_\_
- miscarriages \_\_\_\_\_

- Regular self breast exams
- Breast pain/tenderness
- Breast lumps
- Nipple discharge

**Male Reproduction**

(questions apply to lifetime, not just last 6 months)

- Discharge or sores on penis
- Hernias
- Prostate disease
- Are you sexually active?
- Impotence
- Premature ejaculation
- Use condoms
- Testicular masses or pain
- Chlamydia
- Gonorrhea
- Condyloma/genital warts
- Genital herpes
- Syphilis

I certify that the above information is true to the best of my knowledge

\_\_\_\_\_  
 Patient signature

\_\_\_\_\_  
 Date