

**PATIENT/CLIENT INTAKE FORM**

Please allow 30-45 minutes to complete most of this questionnaire. Please answer the questions below as thoroughly as possible so that we may make the best possible clinical assessment. This helps us develop a realistic and workable plan for supporting you in reaching your health goals. Your answers to personal questions such as relationship status, religion, etc. are important as they provide helpful context for establishing a productive partnership with you and for the purpose of using the most respectful language when addressing you. That said; please answer only the questions you are comfortable answering.

**PATIENT/CLIENT CONTACT**

Patient/Client Name:

Last Name First Name Middle Name

\_ DOB

What is your preferred pronoun? (Add drop down options)

What is your preferred name? (Nickname, chosen name, etc.)

Address:

City: State: \_ Zip Code:

Home Phone: Work Phone:

Cell Phone: Email Address:

Preferred Contact Number:  Cell  Home  Work

**HOW DID YOU HEAR ABOUT US?**

Walk-in Friend Family Work Student Referring Physician

Healthcare Provider Newspaper Mailer Sign/Billboard Television Social Media MUIH Website

Magazine/Published Material Wellness Minute on Facebook Other \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**PRIMARY CARE PROVIDER**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone Number \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_Fax Number­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 I do not have Primary Care Provider.

**EMERGENCY CONTACT**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone Number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**DEMOGRAPHICS**

What is your gender? Male Female Other

Interpreter needed? Yes No Primary Language:

Ethnic Group (Select One): Hispanic Non-Hispanic Are you a US Veteran? Yes No

Race (Select all that apply): Asian African American Caucasian Alaskan Native Pacific Islander American Indian

Relationship Status: Single Married Divorced Widowed Partnered Separated

Highest Level of Education: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Occupation:

Employer:

Employment Status (Check one): Full Time Not Employed Part Time Retired Seasonal Self Employed Volunteer

Student (Full Time) Student (Part Time) MUIH Student

**I certify the above information is true and correct to the best of my knowledge.**

**Printed Name of Legal Guardian (if under 18 years of age)**

**Signature of Client or Legal Guardian Signature Date**

**REASONS FOR SEEKING CARE –**

1. What is your main reason for coming to the clinic today?

2. Are you seeking care for specific health problems, symptom, or conditions? (Please list)

**MEDICAL HISTORY: PERSONAL & FAMILY**

Current Height:

Current Weight:

What, if any, surgeries, operations, or procedures have you undergone, and when?

Have you ever been hospitalized for reasons other than surgeries/operations?

If so, when and for what reason(s)?

**Personal & Family Health History:**

Please check box to indicate if you or a biological family member has ever had the following conditions. If condition does not apply, leave blank.

For personal health history, indicate P for past conditions or C for current conditions.

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| Medical Condition | Self | Mother | Father | Sibling(s) | Other family member |
| Allergies |  |  |  |  |  |
| Alcohol/Drug Addiction |  |  |  |  |  |
| Anemia |  |  |  |  |  |
| Anxiety |  |  |  |  |  |
| Arthritis |  |  |  |  |  |
| Cancer |  |  |  |  |  |
| Cataracts |  |  |  |  |  |
| Clotting disorder |  |  |  |  |  |
| Depression |  |  |  |  |  |
| Diabetes |  |  |  |  |  |
| Fibromyalgia |  |  |  |  |  |
| GERD |  |  |  |  |  |
| Glaucoma |  |  |  |  |  |
| Heart Disease |  |  |  |  |  |
| High Cholesterol |  |  |  |  |  |
| High Blood Pressure |  |  |  |  |  |
| HIV/AIDS |  |  |  |  |  |
| Irritable Bowel Syndrome |  |  |  |  |  |
| Kidney Disease |  |  |  |  |  |
| Lyme Disease |  |  |  |  |  |
| Mental Illness (other than anxiety or depression) |  |  |  |  |  |
| Nerve/Muscle Disease |  |  |  |  |  |
| Osteoporosis |  |  |  |  |  |
| Parkinson's/dementia/Alzheimer's |  |  |  |  |  |
| PTSD |  |  |  |  |  |
| Respiratory Diseases (e.g., COPD, emphysema) |  |  |  |  |  |
| Seizures |  |  |  |  |  |
| Sickle cell anemia |  |  |  |  |  |
| Stroke |  |  |  |  |  |
| Thyroid disease |  |  |  |  |  |
| Ulcers |  |  |  |  |  |
| Vision problems |  |  |  |  |  |
| Other |  |  |  |  |  |

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| --- | --- | --- | --- |
| **Pregnancies *(please include losses/terminations)*** | | | |
| Year | Vaginal/C Section | Sex | Complications/Other Things You Want to Mention |
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**For Women:**

Are you currently pregnant? Are you actively trying to conceive? Are you breastfeeding?

Date of last menstrual period:

How long is your cycle?

How long between cycles:

Do you have any issues with mood changes, pain/cramping, or other menstrual concerns?

Do you utilize contraception? Yes / No

If yes, what type(s)?:

**HEALTH-RELATED BEHAVIORS**

**DIET**

1. In general, how healthy is your overall diet?  
   Poor  FairGood Very Good Excellent 
2. Are you satisfied with your diet? Yes/No

|  |  |
| --- | --- |
| **SLEEP** |  |
| At what time are you typically in bed? |  |
| What time do you fall asleep? |  |
| Do you have difficulty falling asleep? |  |
| Do you have difficulty staying asleep? |  |
| Typical total hours asleep? |  |
| # of times you awaken during the night |  |
| Do you feel rested upon rising? |  |

|  |  |
| --- | --- |
| **PHYSICAL ACTIVITY** |  |
| How would you categorize your activity level? | Sedentary  Mildly Active Moderately Active  Very Active |
| How many days per week do you exercise? |  |
| What types of exercise do you do?  (Check all that apply) | Cardio  Strength Flexibility EnduranceBalance |
| What is the general intensity when you exercise? | Mild  Moderate Strenuous |

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| **STRESS** | | | | | | | |
| On a scale of 1-10, with 1 being low and 10 being high, how stressful is your: | | | | | | | |
| Work: |  | Social/family situation: |  | Current health status: |  | Life in general: |  |
| What do you do to cope with stress? | | |  | | | | |
| Do you feel that your current state of health is: | | | largely in your control or       largely out of your control | | | | |

**LIFESTYLE**

1. What are your hobbies and interests?
2. How do you typically spend your day?
3. With whom do you live? (Include roommates, spouse, children, relatives, pets, etc.)

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| --- | --- | --- | --- | --- | --- | --- | --- |
|  |  | | | | | | |
|  | | Frequency | | | | | Comments |
| Never | less than once/month | Monthly | Weekly | Daily |
| Social Activity | |  |  |  |  |  |  |
| Relaxation | |  |  |  |  |  | What types(s)? |
| Spiritual/Religious practice | |  |  |  |  |  |  |
| Mindfulness  Practices | |  |  |  |  |  | What type(s)? |
| Alcohol | |  |  |  |  |  |  |
| Tobacco | |  |  |  |  |  |  |
| Recreational  Drugs | |  |  |  |  |  |  |
| Sexual Activity | |  |  |  |  |  |  |

**Significant Life Events:**

Please list any major events of your life and the dates they occurred. Include births, deaths, marriage, divorce, accidents, moves, job changes, miscarriages, illness, and anything else you feel greatly impacted your life.

Date Event

**MEDICATIONS/SUPPLEMENTS**

Please list any medications you are taking currently or take on a regular basis (including over the counter medications)

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| --- | --- | --- | --- | --- | --- |
| Name | Dose | Frequency | Reason for Taking | Prescribing Provider | Start date |
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Please list any herb, vitamin, or supplement products you are taking currently or take on a regular basis. Please include brand names. If your product has a number of ingredients it can be helpful to bring it with you to your visit.

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| --- | --- | --- | --- | --- |
| Name | Dose | Frequency | Reason for Taking | Start date |
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**HEALTH ASSESSMENT/SYMPTOM QUESTIONNAIRE**

**Medical Symptom Questionnaire**

Point Scale:

O = Never or almost never have the symptom.

1 = Occasionally have it; effect is not severe.

2 = Occasionally have it; effect is severe.

3 = Frequently have it; effect is not severe.

4 = Frequently have it; effect is severe.

The Medical Symptom Questionnaire was developed by Jeffrey Bland, PhD.

Use this questionnaire to chart your health and progress. Rate each

of the following symptoms based on your health for the past thirty days.

**Digestive Tract Head**

\_\_\_\_\_ Nausea or vomiting \_\_\_\_\_Headaches

\_\_\_\_\_Diarrhea \_\_\_\_\_Faintness

\_\_\_\_\_Constipation \_\_\_\_\_Dizziness

\_\_\_\_\_Bloated feeling \_\_\_\_\_Insomnia

\_\_\_\_\_Belching or passing gas \_\_\_\_\_**Total**

\_\_\_\_\_Heartburn

\_\_\_\_\_**Total Heart**

\_\_\_\_\_Irregular or skipped heartbeat

**Ears \_\_\_\_\_**Rapid or pounding heartbeat

\_\_\_\_\_Itchy ears \_\_\_\_\_Chest Pain

\_\_\_\_\_Earaches, ear infections \_\_\_\_\_**Total**

\_\_\_\_\_Drainage from ear

\_\_\_\_\_Ringing in ears, hearing loss **Joints/Muscles**

\_\_\_\_\_**Total \_\_\_\_\_**Pain or aches in joints

**\_\_\_\_\_**Arthritis

**Emotions \_\_\_\_\_**Stiffness or limitation in movement

\_\_\_\_\_Mood swings \_\_\_\_\_Pain or aches in muscles

\_\_\_\_\_Anxiety, fear, or nervousness \_\_\_\_\_Feeling of weakness or tiredness

\_\_\_\_\_Anger, irritability or aggressiveness \_\_\_\_\_**Total**

\_\_\_\_\_**Total**

**Lungs**

**Energy/Activity \_\_\_\_\_**Chest congestion

\_\_\_\_\_Fatigue, sluggishness \_\_\_\_\_Asthma, bronchitis

\_\_\_\_\_Apathy, lethargy \_\_\_\_\_Shortness of breath

\_\_\_\_\_Hyperactivity \_\_\_\_\_**Total**

\_\_\_\_\_Restlessness

\_\_\_\_\_**Total Mind**

**\_\_\_\_\_**Poor memory

**Eyes \_\_\_\_\_**Confusion, poor comprehension

\_\_\_\_\_Watery or itchy eyes \_\_\_\_\_Poor concentration

\_\_\_\_\_Swollen, reddened, or sticky eyelids \_\_\_\_\_Difficulty in making decisions

\_\_\_\_\_Bags or dark circles under eyes \_\_\_\_\_Stuttering or stammering

\_\_\_\_\_Blurred or tunnel vision \_\_\_\_\_Learning disabilities

\_\_\_\_\_Slurred speech \_\_\_\_\_**Total**

\_\_\_\_\_**Total**

**Skin**

**Mouth/Throat \_\_\_\_\_**Acne

\_\_\_\_\_Chronic coughing \_\_\_\_\_Hives, rashes, or dry skin

\_\_\_\_\_Gagging, frequent need to clear throat \_\_\_\_\_Hair Loss

\_\_\_\_\_Sore throat, hoarseness, loss of voice \_\_\_\_\_Flushing or hot flashes

\_\_\_\_\_Swollen or discolored tongue, gums, lips \_\_\_\_\_Excessive sweating

\_\_\_\_\_Canker sores \_\_\_\_\_**Total**

\_\_\_\_\_**Total**

**Weight**

**\_\_\_\_\_**Binge eating/drinking

**Nose** \_\_\_\_\_Craving certain foods

\_\_\_\_\_Stuffy nose \_\_\_\_\_Excessive weight

\_\_\_\_\_Sinus problems \_\_\_\_\_Compulsive eating

\_\_\_\_\_Hay fever \_\_\_\_\_Underweight

\_\_\_\_\_Sneezing attacks \_\_\_\_\_Water retention

\_\_\_\_\_Excessive mucus formation

\_\_\_\_\_**Total**

**Other**

\_\_\_\_\_Frequent illness

\_\_\_\_\_Genital itch or discharge

\_\_\_\_\_**Total**

\_\_\_\_\_**Grand Total**

**Is there anything else that you would like your provider to know?**

***Thank you for taking the time to complete this questionnaire.***