**Journey to Health Inc.**

**New Patient Intake Form**

Patient Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Sex: Male or Female Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 Street # Street Name PO Box #

 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 City Province Postal Code

Phone numbers: Home # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Work # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Fax # \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Journey to Health? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last date you felt well and healthy: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Describe your overall health? Excellent\_\_\_\_ Good\_\_\_\_ Fair \_\_\_\_ Poor \_\_\_\_\_

Health Issues in order of concern:

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How is home life?

What are Stressors in your life? Family Situation?

List Injuries and date (close as possible):

Have you been hospitalized? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

Reason for Hospitalization and dates:

List any Chronic Medical Conditions:

Do you have Allergies? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_

List Allergies and date since Allergy was identified.

List Prescription Medications that you take:

Medication Dose Reason Date Started

List Prescription Medications that you took in the past:

Medication Dose Reason Date Started

List all Vitamins, Supplements, Homeopathic Remedies that you are taking:

Medication Dose Reason Date Started

List all Over The Counter Medications that you are taking:

Medication Dose Reason Date Started

Do you eat three meals per day? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_

What did you eat yesterday?

Breakfast: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Lunch \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Dinner \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Snack \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is this typical eating pattern? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_

Any dietary restrictions? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much water do you drink daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much juice daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much coffee daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much Tea daily and what type: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much Milk daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How much Alcohol daily? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ weekly? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you smoke? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drugs? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you exercise? Yes \_\_\_\_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Type of exercise and frequency:

Do you spend time outdoors? When and how often?

How much sleep do you get? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Do you sleep well? Yes \_\_\_\_\_ No \_\_\_\_\_\_

What is your usual bedtime? \_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you wake feeling refreshed and ready for the day? Yes \_\_\_\_\_\_ No \_\_\_\_\_\_\_\_\_

Describe sleep (how you fall asleep, waking at night, restlessness, sleep apnea, nightmares, routine):

Please describe medical history of your family:

Please indicate if you currently have or had in the past any of the following conditions/symptoms:

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Condition/Symptom** | **Past** | **Present** | **Condition/Symptom** | **Past** | **Present** |
| Acne |  |  | Urgency to Void |  |  |
| Alcohol Abuse |  |  | Inability to Void |  |  |
| Allergies |  |  | Frequent Urinary Infection |  |  |
| Bronchitis |  |  | STD’s |  |  |
| Eczema |  |  | Unusual Discharge |  |  |
| Hives |  |  | Painful Menses |  |  |
| Headaches |  |  | PMS |  |  |
| Migraines |  |  | Join Pain and Stiffness |  |  |
| Dizziness  |  |  | Arthritis |  |  |
| Hayfever |  |  | Osteoporosis |  |  |
| Glaucoma |  |  | Osteopenia |  |  |
| Cataracts |  |  | Broken Bones |  |  |
| Hearing Loss |  |  | Muscle Weakness |  |  |
| Ringing in Ears |  |  | Joint Swelling |  |  |
| Sinus Problems |  |  | Back Pain |  |  |
| Frequent Sore Throats |  |  | Concussion |  |  |
| Gingivitis |  |  | Varisoce Veins |  |  |
| Dental Cavaties |  |  | Leg Cramps |  |  |
| Goitre |  |  | Thrombophlebitis |  |  |
| Pnemonia |  |  | Leg Cramps |  |  |
| Wheezing |  |  | Cold Hands/Feet |  |  |
| Difficulty Breathing |  |  | Fainting |  |  |
| Shortness of Breath |  |  | Seizures/Convulsions |  |  |
| Tuberculosis |  |  | Paralysis |  |  |
| Heart Disease |  |  | Loss of Memory |  |  |
| Angina |  |  | Speech Problems |  |  |
| High Blood Pressure |  |  | Thyroid Problems |  |  |
| Low Blood Pressure |  |  | Diabetes |  |  |
| Heart Murmur/Palpitations |  |  | Hormone Therapy |  |  |
| Breast Lumps |  |  | Anemia |  |  |
| Breast Pain |  |  | Easy Bleeding/Bruising |  |  |
| Trouble Swallowing |  |  | Blood Transfusion |  |  |
| Heartburn |  |  | Leukemia |  |  |
| Unusual Thirst |  |  | Cancer |  |  |
| Naseau |  |  | Vaccine Reactions |  |  |
| Gas/belching |  |  | Depression |  |  |
| Ulcers |  |  | Anxiety |  |  |
| Jaundice |  |  | Phobias |  |  |
| Liver Disease |  |  | Bipolarism |  |  |
| Gallbladder Disease |  |  | Drug Abuse |  |  |
| Prolonged Diarrhea |  |  | Insomnia |  |  |
| Bloody Stools |  |  | Post Partum Depression |  |  |
| Constipation |  |  | Fibromyalgia |  |  |
| Indigestion |  |  | AIDS |  |  |
| Hemorrhoids |  |  | ADD |  |  |
| Endometriosis |  |  | ADHD |  |  |
| Hernia |  |  | HIV |  |  |
| Kidney Stones |  |  |  |  |  |