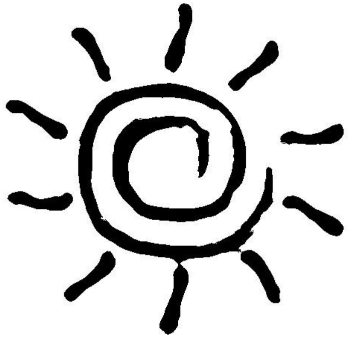

Essential Health

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New Patient Intake Form

First and Last Name	
Preferred name	
Date of Birth	
Address	
Alternate Address	
Home Phone Number	
Work Phone Number	
Cell Phone Number	
Fax Number	
(please circle the preferred phone number)	
Email Address	
Pharmacy Name	
Pharmacy Phone Number	
Pharmacy Fax Number	
Primary Care Physician	
Physician Phone Number	
Physician Fax Number	
Credit Card Type (Visa, MC)	
Credit Card Number	
Expiration Date	
Security Code	
Credit Card's Zip Code	

Referred by: ____

What is the main reason you are coming to Essential Health?

____

When was the last time you felt well? ______________________
Did something trigger your change in health? ______________________
What makes you feel better? ______________________
What makes you feel worse? ______________________

Please provide a **brief description of your illness**. (Attach an additional page if needed)
Have you ever had any "alternative medicine" workup or testing? If so, please be sure to include details regarding that. ____

Past Medical History:

Surgeries

Hospitalizations

Medications

Vitamins/Supplements

Allergies to medications

Social History:

Current marital status:
Married/Single/Widowed/Gay/Lesbian/Long-term Relationship/Divorced

Do you smoke? Yes/No *Now/Past*
How much? ____________
For how many years? ____________
When did you quit? ____________
Do you drink alcohol? Yes/No *Now/Past*
How much? ____________
Do you use illicit drugs? Yes/No *Now/Past*
What drugs? ____________
Do you identify a religion? ____________

Do you have pets in the house? ____________________
What is your occupation? ____________________
Do you exercise? *(If not, what prevents you?)* ____________________
How often? ____________________
What kind of exercise? ____________________
Are you on any special diet? *(If so, please describe)* ____________________
____

Do you have children? (if so, what ages and what are their names?)
____
____
____

Who lives in your house?
____
____
____

Family History:

	Alive or Dead	Current age or age of death	Medical conditions they had
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

OB/GYN History (women only)

How old were you when you started menstruating? ______________
Have you ever been pregnant? ______________
How many times? ______________
How many vaginal deliveries? ______________
Cesarean sections? ______________
Abortions? ______________
Miscarriages? ______________
Ectoptic pregnancies? ______________
Did you breastfeed? If so, for how long? ______________
Did you have: post partum depression/toxemia of pregnancy/gestational diabetes/baby over 8 pounds

Are you in menopause? y/n ______________
If yes, at what age did you stop having periods? ______________
What have you used now or in the past for contraception?

IUD/ Birth Control Pills/Diaphragm/Vasectomy/Tubal ligation/Rhythm Method

Are you satisfied with your sex life? ________________

Gastrointestinal history

Have you used frequent antiobiotics? If yes, please give details ____________________________

____

____

Have you ever taken steroids? If yes, please give details ________________________________

____

____

Have you used antacids? (TUMS, Prilosec, Prevacid, Zantac, etc) __________________________

____

Have you ever had traveler's diarrhea? If yes, please give details __________________________

____

____

Have you ever been diagnosed with a parasite? If yes, please give details _____________________

____

____

Men's history

(please circle appriopriate)

Abnormal PSA	Difficulty maintaining an erection
Frequent urination	Prostate enlargement
Prostatitis	Loss of control of urine
Urgency	Hesitancy/difficulty starting urinary stream
Decreased libido	

Are you satisfied with your sex life? _________

Exposure History

Do you have silver fillings? _________

Root canals? _________

Implants? _________

Do you get flu shots? _________

Do you drive a hybrid car? _________

Do you play golf? _________

Have you traveled to any under developed countries? ________________________________

Were you ever treated for acne with antibiotics? ________________________________

Do you dry clean your clothes frequently? ________________________________

Have you had any prolonged exposure to mold? ________________________________

Any known exposure to chemicals or heavy metals? ________________________________

Do odors or fumes affect you negatively? ________________________________

Birth History

Were you full term? ____________________________

Were you breast fed? ____________________________

Were you delivered vaginally? ____________________________

Did you have a lot of antibiotic use as a child? ____________________

Are you very fatigued after exercise? ____________________
Do you sweat with exertion? ____________________

Psychosocial history

Are you happy? ____________________
Have you experienced major losses? ____________________
Was your childhood safe, secure and loving? ____________________
Have you ever been the victim of abuse or trauma? ____________________
Is stress interfering with your life? ____________________
Do you like your work? ____________________
Rate, on a scale of 1-10, these stressors:
Family __________
Finances __________
Job __________
Health __________

Do you feel you easily handle the stresses in your life? ____________________

Sleep History

How many hours a night do you sleep on average? ____________________
Do you have trouble falling asleep? ____________________
Do you have trouble staying asleep? ____________________
Do you wake up at night to urinate? *(If so, how many times?)* ____________________
Do you have trouble going back to sleep? ____________________
Do you snore? ____________________
Do you use sleep aids? ____________________
Are you refreshed when you wake up? ____________________

Symptom review (Yes or No)

General		Head/eye/ears	
Cold hands and/or feet		Ear ringing	
Non refreshing sleep		Sensitivity to loud noises	
Dip in energy in afternoon		Eye crusting	
Fatigue		Circles under eyes	
Intolerance to cold		Hearing loss	
Intolerance to heat		Headaches	
Frequent rashes		Migraine headaches	
Low body temperature			
Low blood pressure			
Brain fog			
No dream recall			

Musculoskeletal

Muscle cramps	
Foot cramps	
Muscle twitching	
Eye twitching	
Muscle spasms	
Arthritis	
TMJ syndrome	
Muscle or joint stiffness	
Tendonitis	
Tension headaches	

Mood/nerves

Anxiety	
Depression	
Suicidal thoughts	
Dizziness	
Irritability	
Panic attacks	
Paranoia	
Fearfulness	
Tremor	
Numbness – where?	
Fainting	
Seizures	
Difficulty with thinking	
Focus	
Concentration	
Memory	

Eating

Frequent dieting	
Inability to lose weight	
Salt cravings	
Carbohydrate cravings	
Sweet cravings	
History of eating disorder	

Cardiovascular

Palpitations	
Chest pain	
Heart murmur	
Irregular pulse	
Varicose veins	
Swollen ankles	

Digestion

Constipation	
Diarrhea	
Fluctuations between diarrhea and constipation	
Excessive gas	
Bloating	
Bleeding gums	
Blood in stools	
Small caliber stools	
Cold sores	
Cracking at corners of lips	
Dry mouth	
Difficulty swallowing	
Heartburn	
Reflux	
Indigestion	
Undigested food in stool	
Hemorrhoids	
Anal fissures	
Nausea	
Vomiting	
Mucus in stools	
Periodontal disease	
Strong stool odor	

Skin problems

Dry skin	
Oily skin	
Hair loss	
Acne	
Rashes	
Bumps on back of arms	
Cellulite	
Athlete's foot	
Easy bruising	
Eczema	
Genital herpes	
Hives	
Jock itch	
Vitiligo	
Strong body odor	
Moles that are changing	
Itching of skin	
Dandruff	
Cracking heels	

Respiratory

Shortness of breath	
Asthma	
Emphysema	
Nasal stuffiness	
Nasal allergies	
Post nasal drip	
Bad breath	
Cough	
Nose bleeds	
Sinus infections	
Wheezing	

Nails

Weak, brittle nails	
Bitten nails	
Ridged nails	
Spots on nails	
Fungus on nails	
Thickening of nails	

Female reproductive | Male Reproductive

Female reproductive		Male Reproductive	
Breast cysts/lumps		Lumps in testicles	
Breast tenderness		Impotence	
Ovarian cysts		Discharge from penis	
Decreased sex drive		Prostate infections	
Vaginal discharge		Problems with ejaculation	
Vaginal odor		Infertility	
Vaginal itching		Decreased libido	
Vaginal pain with intercourse			
Vaginal dryness			
Endometriosis			
Fibrocystic breasts			
Fibroids			
Decreased libido			
Fluid retention			
Menstrual migraines			
Heavy periods			
PMS			
Irregular periods?			
Hot flashes			

Urinary

Urinary	
Leaking/incontinence	
Frequency	
Infections	
Urgency	

Please complete this form and return it to Essential Health before your appointment. You can either mail it, fax it or scan and email it to us.
Thank you and see you soon!