



**PLEASE NOTE:** The Patient Intake form is a fillable PDF document. Please save the document to your computer before filling in the blank form. If you open the document directly from your email box, and fill in the form boxes, your information will not be saved. Also, please open the document in Adobe Reader or Acrobat, not in Previewer (MAC users). Your information will not be saved when completing data in Previewer.

### PATIENT INTAKE FORMS

\*For Office Use Only

Date of First Appointment \_\_\_\_\_ Practitioner \_\_\_\_\_

Name: \_\_\_\_\_ Age \_\_\_\_\_ Date of Birth: \_\_\_\_\_

Address: \_\_\_\_\_ City \_\_\_\_\_ State \_\_\_\_\_ Zip Code \_\_\_\_\_

Mailing Address (if different): \_\_\_\_\_

Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_

Fax: \_\_\_\_\_ E-mail: \_\_\_\_\_

Employment Status: Full-time Part-time Student Retired Unemployed Other \_\_\_\_\_

Occupation: \_\_\_\_\_ (If retired, state previous occupation)

Employer and address: \_\_\_\_\_

Support activities/pursuits/groups: \_\_\_\_\_

Relationship Status: Single Married Divorced Widowed

Living Situation: Alone Friend(s) Partner Spouse Parents Children Pets: \_\_\_\_\_

Names and ages of those living with you: \_\_\_\_\_

EMERGENCY CONTACT

Name and Relationship to Patient \_\_\_\_\_

Phone #1 \_\_\_\_\_ Phone #2 \_\_\_\_\_

FINANCIAL AGREEMENT

I claim full financial responsibility for services rendered at MCNH for \_\_\_\_\_ CLIENT  
and understand that payment is required in full at the time of service.

Signed: \_\_\_\_\_ Relationship to client: \_\_\_\_\_

How did you hear about MCNH?: \_\_\_\_\_

Have you ever tried natural medicine or alternative therapies? \_\_\_\_\_

If so, describe type and frequency:

Therapy	Frequency

Main health concern you wish to address at this time:

CANCER INFORMATION

Have you ever been diagnosed with cancer, a mass or tumor?      Yes      No

When? \_\_\_\_\_

Location \_\_\_\_\_

Type? \_\_\_\_\_

Current Status (eg; post-surgery, recurrence, etc.) \_\_\_\_\_

Current Stage \_\_\_\_\_

Relevant tumor markers \_\_\_\_\_

CONVENTIONAL TREATMENT HISTORY	
Procedure Date (surgery, chemo, radiation, etc.)	Duration

If you are in a clinical trial or experimental protocol please provide details.

CURRENT/RECENT HEALTH CARE PROVIDERS		
Provider Name	Date(s)	Care Provided (surgery, oncology, PCP, etc.)

HOSPITALIZATION(S) [NON-CANCER]			
Date	Hospital/Facility	Diagnosis/Operation	Provider Name

ACCIDENTS/INJURIES (describe briefly)

MORE than 5 years ago \_\_\_\_\_

LESS than 5 years ago \_\_\_\_\_

FAMILY HISTORY					
Please include any of the following: Alcoholism, high blood pressure, cancer, diabetes, heart- disease, osteoporosis, other addiction or illness.					
Member	Living?	Current Age	Important Diseases	Cause of Death	Age at Time of Death
Mother					
Father					
Siblings					
Siblings					
*MGM					
* MGF					
*PGM					
*PGF					

\* M = Maternal P = Paternal GM = Grandmother GF = Grandfather

PERSONAL HISTORY

In general, I feel my overall health is:      Excellent      Good      Fair      Poor

Mark the following: 1 - IF CURRENT and 2 – IF PAST

	Asthma		Ringing In Ear		Palpitations		Migraines
	Bronchitis		Sciatic Pain		Tightness In Chest		Frequent Headaches
	Pneumonia		Frequent Urination		Rheumatic Fever		Frequent Depression
	Frequent Colds/Flu		Dribbling Urine		Heart Problems		Jaundice
	Epstein-Barr		Painful Urination		Poor Sleep		Hepatitis
	Chronic Fatigue		Scanty Urination		Hypoglycemia		Hemorrhoids
	Mononucleosis		Blood In Urine		Severe Mood Swings		Eye Problems
	HIV Positive		Prostate Problems		Diabetes		Photophobia
	AIDS		No/Low Sex Drive		Overweight		Dizziness
	Allergies		Impotence/Sexual Difficulty		Underweight		Stroke
	Sinus Congestion		Afternoon Persp./Fever		Eating Disorder		Varicose Veins
	Colitis		Night Sweats		Gum/Teeth Problems		Drug Addiction
	Crohn's Disease		Hearing Problems		Lots of Fillings		Alcoholism
	Diverticulitis		Tinnitus		TMJ		Epilepsy
	Parasites		Memory Difficulty		Concussion		Frequent Anger
	Gas		Anxiety/ Stress		Frequent Frustration		Bloating
	Arthritis		PTSD		ADD/ADHD		

Other:

Height \_\_\_\_\_ Weight \_\_\_\_\_ Blood Pressure \_\_\_\_\_

Skin:      dry      oily      normal

Please rate the following on a scale of 1 to 10: (10 being the best) and write in any comments

Condition	Rating (1 – 10)	Comments
Sleep		
Appetite		
Energy Level		
Digestion		

Any gas, bloating or other discomfort after eating?      Yes      No (Describe: \_\_\_\_\_)

Stools:      float      sink      daily      bad odor      no odor      blood in stool

Please report how often, and what type/brand, you use any of the following for bowel elimination?

Enemas \_\_\_\_\_ Laxatives \_\_\_\_\_ Purgatives \_\_\_\_\_

How do you feel about the following areas of your life? Please check appropriate boxes & make any comments you would like to make.

	Great	Good	Fair	Poor	Comments
Self					
Work					
Partner					
Sex					
Family					
Diet					
Exercise					

Please rate your stress on a scale of 0 to 10: (10 being the most) and write any comments:

	Yes	No
I worry a great deal		
I feel lonely		
I am bored with my life		
I think a lot about dying		
I have particular concerns relating to my religion		
I feel fearful or afraid		
I feel nervous most of the time		
I often feel depressed		
I feel anxious often		
I am ill frequently		
I sometimes feel weak or light-headed		
I often have pains in my shoulders, neck, and/or back		
I often feel like crying		
I lose my temper more than I used to		

Other personal concerns (please describe):

Please use this space to add any other information about yourself that you think will be of help to us

DIET AND EXERCISE:

Dietary preferences/restrictions: \_\_\_\_\_

What is your favorite food? \_\_\_\_\_ Favorite flavor? \_\_\_\_\_

Sample of day's menu (Please also fill out 3-day food chart if you have been asked to do so)

Breakfast	
Lunch	
Dinner	
Snacks	
Drinks/beverage(s)	

Do you exercise regularly?    Yes    No

If yes, what type of exercise do you do? \_\_\_\_\_

\_\_\_\_\_

How often? \_\_\_\_\_

Tobacco use:    Current    Previous    How many years? \_\_\_\_\_

How much? \_\_\_\_\_

Alcohol use:    Yes    No    How often? \_\_\_\_\_

How much? \_\_\_\_\_    How many years? \_\_\_\_\_

Caffeine use:    Yes    No

How much? \_\_\_\_\_    How often? \_\_\_\_\_

Other mood altering substances:

Which? \_\_\_\_\_ Past/Present? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Which? \_\_\_\_\_ Past/Present? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

Which? \_\_\_\_\_ Past/Present? \_\_\_\_\_ How much? \_\_\_\_\_ How often? \_\_\_\_\_

To the best of your knowledge, have you ever been exposed to pesticides, toxic chemicals, heavy metals, radiation, or other toxins beyond those encountered in daily life? Please describe:

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

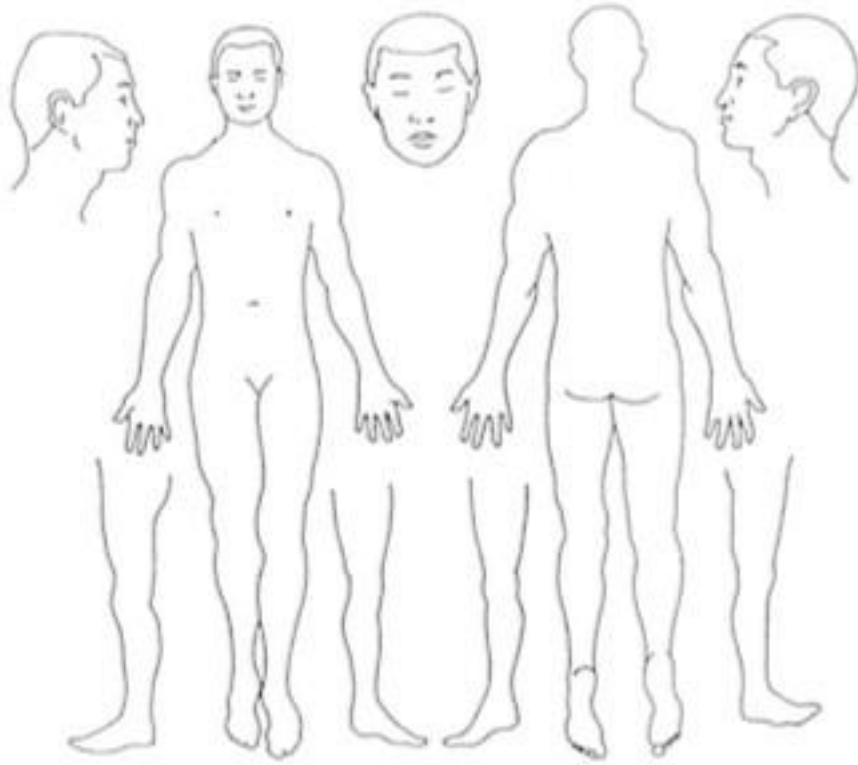
\_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

CURRENT DIETARY SUPPLEMENTS AND HERBS (Use separate sheet if necessary)				
Product Name	Brand Name	Potency (mg, IU, etc.)	Dose	Frequency

CURRENT PRESCRIPTION MEDICATIONS – Please list all prescription and over-the-counter medications you are currently taking (this should not include chemo and radiation)					
Medication	Indication	Duration	Strength	Dose	Frequency



Area/Description of Symptom(s)/Pain & Frequency	Pain Level 0 to 10 (10 being the highest)



**QUESTIONS ON THIS PAGE ARE FOR FEMALE PATIENTS ONLY**

**MENSTRUAL PERIODS** – Please complete this section to the best of your ability, even if you no longer menstruate. It provides valuable information for an accurate assessment.

Menstruating since age: \_\_\_\_\_

Regular    Light    Heavy    Clots    PMS

Color of blood \_\_\_\_\_ Menstrual cramps? \_\_\_\_\_ Which days? \_\_\_\_\_

Flow lasts how many days? \_\_\_\_\_ Length of Cycle? \_\_\_\_\_ Date of last menses \_\_\_\_\_

Mark the following: 1 – IF CURRENT and 2 – IF PAST

	Hysterectomy		Herpes		Mastectomy
	D & C		Yeast Infections		Lumpectomy
	Tubular Ligation		Interstitial Cystitis		Breast Reconstruction
	Ablation		Infertility		Breast Implants
	Irregular PAP Smear		Pain With Intercourse		Fibroids
	Dryness With Intercourse		Osteoporosis		Irregular Bleeding

Vaginal discharge?    Yes    No

Color \_\_\_\_\_ Frequency \_\_\_\_\_ Amount \_\_\_\_\_

**PREGNANCY / BIRTH CONTROL**

Are you pregnant now?    Yes    No

Do you think you might be pregnant?    Yes    No

Number of pregnancies? \_\_\_\_\_ Number of children? \_\_\_\_\_

Tubular pregnancies? \_\_\_\_\_ Number of miscarriages? \_\_\_\_\_

Difficulty conceiving?    Yes    No

**MENOPAUSE**

No menses since \_\_\_\_\_

Experiences/symptoms you are currently feeling/having?

Experiences/symptoms you had in the past during menopause?