MEDERI CENTER
Wholistic Health and Healing
Patient Care | Research | Education

PLEASE NOTE: The Patient Intake form is a fillable PDF document. **Please save the document to your computer before filling in the blank form and open the document in Adobe Reader or Acrobat.** If you open the document directly from your email box, and fill in the form boxes, your information will not be saved. Also, 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? ◯ Yes ◯ No

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 ◯ High ◯ Average ◯ Low

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 below:

	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? _____

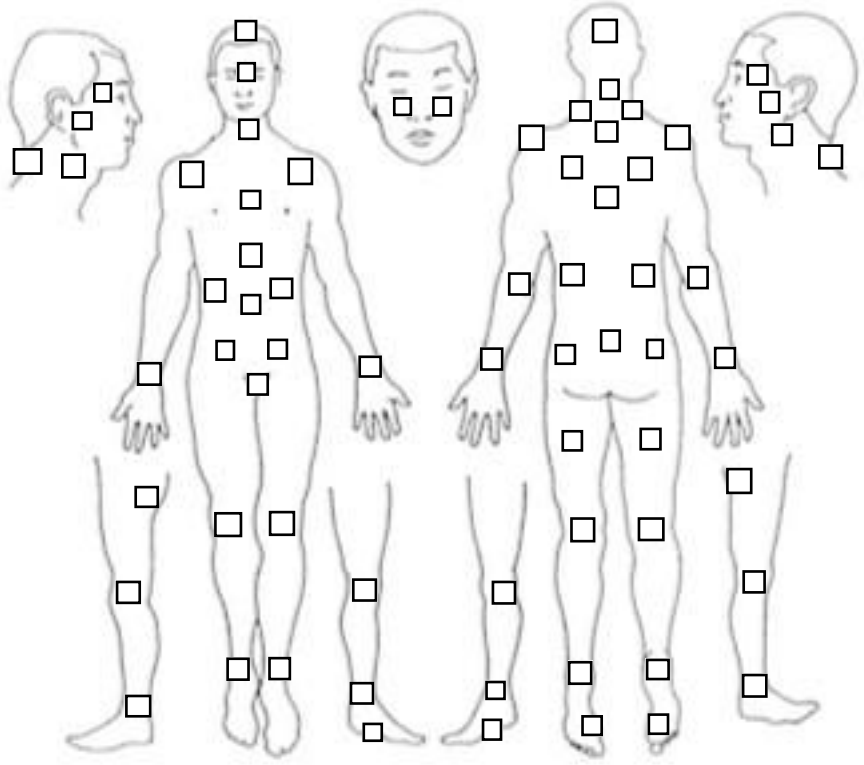
Caffeine use: ☐ Yes ☐ No
How much? _____ How often?_____

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?