Patient Intake Form

Date: _____

First Name: _____ Last Name: _____

Address: _____ Zip: _____

Home phone number: _____ Cell number: _____

Email address: _____

Occupation: _____ Age: _____ DOB: _____

Emergency Contact: _____ Phone: _____

Are you currently receiving health care?_____ Which modality? ☐ MD ☐ DC ☐ L.Ac. ☐ ND ☐ DO

Condition being treated: _____ Is it helping? _____

Name of physician or practitioner: _____

What are the main reasons for your visit today?

1) _____

2) _____

3) _____

Please list tested or suspected allergies or sensitivities and their related symptoms:

Foods: _____

_____

_____

Seasonal: _____

Pets | Drugs | Chemicals | Other: _____

_____

How long have you been having the symptoms? _____

How often are you experiencing the symptoms above? _____

What makes the symptoms better or worse? _____

_____

Are you taking any Medications, Herbs or Supplements? _____

_____

_____

Are you on any specific diet? If so, which one? _____

How often do you consume the following? Please list in the box below.

1= daily 2 = weekly 3 = Monthly 4 = Never

Alcohol	Grains (whole grain)	Smoked Foods
Caffeine	Legumes (beans, lentils, peas)	Soda
Dairy	Meats	Sugary Treats
Fast Food	Nuts / Seeds	Vegetables
Fried Foods	Packaged or Processed Foods	Wheat
Fruit	Salt	Water

How many ounces of water are you drinking each day? _____

Are you constipated? _____ How many bowel movements do you have a day? _____

Do you take any fiber supplements, prebiotics or probiotics? _____

Do you have any current medical condition? (ex: pregnancy, epilepsy, diabetes, etc) _____

What is your daily stress level? ☐ Low ☐ Medium ☐ High

What do you do to relieve stress? _____

Do you exercise regularly? ☐ Yes ☐ No What type of exercise to you typically do? _____

How many hours of sleep do you get each night? _____

What is the quality of that sleep? _____

How did you hear about the clinic? _____

Would you like to receive our e-newsletter containing health and treatment tips? _____

Please read the New Patient Information form. Sign below when you have finished.

Yes, I have read and understand the information listed on the New Patient Information form.

Signature: _____ Date: _____