PATIENT INTAKE

We'd like to welcome you as a new patient. Please take the time to fill out this form as accurately as possible so we can most appropriately address your health needs. The confidentiality of your health information is protected in accordance with federal protections for the privacy of health information under the Health Insurance Portability and Accountability Act (HIPAA). You will notice that we ask questions about race/ethnic and social/lifestyle background. We ask this information as some health issues have a base in your genetic history. Your social history helps us tailor our care so you can successfully implement your treatment plan. Thank you for helping us to meet your needs.

PATIENT DEMOGRAPHICS		
Name: Last, First, MI:		Birth Date/Current Age:
SSN:	Race/Ethnicity:	Genetic Sex/Gender ID:
Mailing Address:		
Preferred Phone:	Cell Phone:	Work Phone:
Email:		
Emergency Contact Name/Phone:		
MEDICAL PRACITIONERS		
Primary Care:	Phone:	Fax:
Other, specify:	Phone:	Fax:
Other, specify:	Phone:	Fax:
SOCIAL HISTORY		
Occupation:		Hours Worked per Week:
Relationship Status:	Partner's Name/Phone:	

HEALTH HISTORY

Your health history is a valuable tool for both you and your provider. It will help us work together to see life-long health patterns and the impact of individual acute events (i.e., surgery, major illness). Please feel comfortable filling out the form completely and honestly. In our practice you are safe from judgment as we work to help you recover and maintain your health.

CURRENT CONCERNS

In order of importance, please identify the health concerns that brought you to the clinic today.

Condition	For How Long?	Successful past treatments?

ALLERGIES

List any foods, drugs, or medications you are hypersensitive or allergic to:

CURRENT MEDICATIONS & SUPPLEMENTS

List all medications (Prescribed & Over the Counter), herbs, vitamins and supplements you currently take:

MAJOR ILLNESSES, ACCIDENTS, HOSPITALIZATIONS & SURGERIES

Include incidents in childhood. Record from recent events working back to childhood.

Event:	Date:	Event:	Date:

FAMILY MEDICAL HISTORY

Blood relatives including: siblings, parents, grandparents, aunts/uncles, 1st cousins. Mark with ***M*** for maternal Relatives and ***P*** for paternal relatives.

Allergies:	Diabetes	Alcoholism
Arteriosclerosis	Seizures	High Blood Pressure
Cancer:	Asthma	Autoimmune disease:
Heart Disease	Stroke	Emotional/Psychological Disorder:
Other:		

LIFESTYLE

Current Weight: Current Height:

Which of the following is a part of you daily life?

Exercise	Coffee/Caffeinated beverages	Dieting
How many times a week?	How many cups per day?	Stress
Relaxation/meditation	Alcohol	Occupational hazards
Tobacco smoking/chewing	How many drinks per week?	Other
	Recreational drugs	

SYMPTOM LIST

Please mark current symptoms with ***C*** and past symptoms with ***P***

Emotional & Mental

Anxiety	Stress	Anorexia	Chronic sadness/grief
Depression	Rate stress level 1-10:	Bulimia	Overly fearful
Manic	Frequent irritability	Frequent Worry	Addictions:
Bipolar	Frequent anger	Obsessive/Compulsive	To what?
	Mood swings		

Immune & Inflammation

Chronic Fatigue Syndrome	Fibromyalgia	Hepatitis A B C	Raynaud's Syndrome
Hashimoto's disease	Frequent illness	Herpes	Connective tissue inflammation
Grave's disease	Frequent infection	Oral Genital	Food allergies
Arthritis:	Hay fever	Chicken pox	Environmental allergies
Lupus	Frequent swollen glands	HIV	Seasonal allergies
Colitis	Cancer	Cold sores	
Crohn's disease		Mononucleosis	

Head, Eyes, Ears, Nose, Throat

Impaired vision	Watery eyes	Runny nose	Toothache
Blurry vision	Impaired hearing	Sinus problems	TMJ/Jaw problems
Eye pain/strain	Ear ringing/Tinnitus	Snoring	Sore throat
Glaucoma	Earaches	Headaches	Dry mouth
Dry eyes	Nose bleeds	Teeth grinding	Dry throat
Red & painful eyes	Bleeding gums		

SYMPTOM LIST continued…

Please mark current symptoms with ***C*** and past symptoms with ***P***

Gastrointestinal & Elimination

Ulcers	Rectal bleeding	Indigestion	**# of Bowel movements per day:**
Increased appetite	Hemorrhoids	Greasy foods upset	
Decreased appetite	Constipation	Bloating after meals	**Type of BM: "normal" loose hard dry soft sticky (sticks to bowl)**
Nausea/Vomiting	Loose stools	Discomfort after eating	
Gas	Diarrhea	Discomfort relieved by eating	
Abdominal pain	Irritable bowel	Gallstones/ Gallbladder disease	**Color of BM: brown pale color green black bloody**
Liver disease	Inflammatory bowel	Undigested food in stools	
Heartburn/Acid reflux	Polyps		
Belching	Leaky gut		

Cardiovascular & Blood

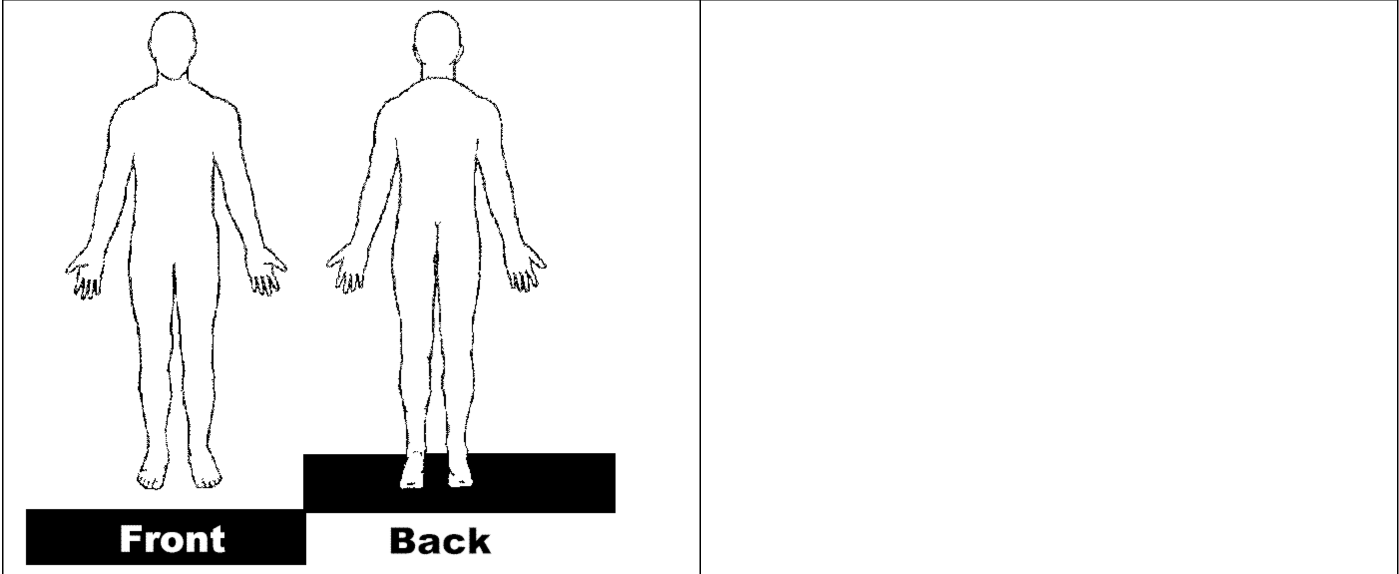
Irregular heartbeat	TIA/Stroke	Cold hands/feet	Anemia
Palpitations, Fluttering	Heart murmurs	Hands & feet go to sleep easily	Swelling of ankles
Chest pain	Rheumatic Fever	Fast pulse (over 100 beats/min)	Heart disease
Chest pressure or tightness	High LDL cholesterol	Slow pulse (under 60 beats/min)	Heart attack
Dizziness	Low HDL cholesterol		Numbness
	High blood pressure		Varicose veins
	Low blood pressure		

Endocrine	Neurological	Respiratory	
Thyroid problems	Seizures/Epilepsy	Pneumonia	Persistent cough
Diabetes Mellitus	Nerve pain	Frequent colds & flu	Pleurisy
Hypoglycemia	Vertigo/Dizziness	Wheezing	Asthma
Feeling hot or cold	Paralysis	Bronchitis	Tuberculosis
Hypo adrenal	Numbness/Tingling	Shortness of breath	Emphysema
	Loss of Balance		

Sleep & Energy	Skin	Urinary System	Blood Sugar Regulation
Insomnia	Rashes	Kidney disease	Emotional eating
Light sleeper/wake easily	Eczema	Painful urination	Excessive appetite
Can't fall back to sleep	Hives	Frequent urinary tract infection	Hungry between meals
Fatigue	Rosacea	Frequent urination in general	Irritable before meals
Tired during day but awake at night	Dandruff	Frequent urination at night	Get shaky if hungry
Can't relax	Fungal infections	Lack of bladder control	Afternoon headaches
Poor memory	Warts	Kidney stones	Crave sweets in afternoon
Fuzzy thinking	Psoriasis	Impaired urination	Compulsive eating
Sleep with pets (in room or in bed)	Sweat easily during day	Blood in urine	Frequent dieting
	Sweat easily at night		Frequent overeating
	Never sweat		
	Itchy skin		
	Dry skin		
	Bruise easily		
	Acne		
	Boils		

Musculoskeletal

Note any current joint, muscle, tendon, or ligament problems. Please include: 1) Cause 2) Diagnosis 3) When problem started 4) Helpful Treatments. Check areas of persistent pain on the diagram below.



ORAL HEALTH

Number of times you brush per day________________________

Type of toothbrush: manual electric

If electric, type: ____

Toothpaste:____

Mouthwash:____

Number of times you floss:_____________________________

Date last dental cleaning:______________________________

Orthadontia dates:___________________________________

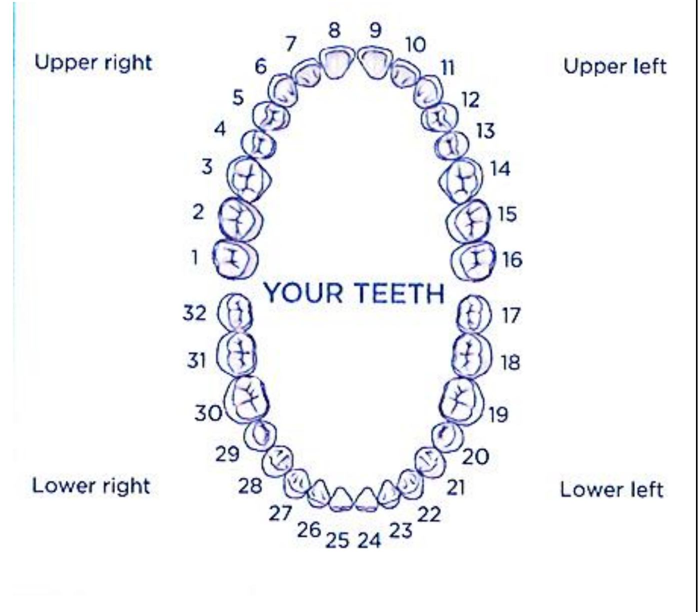
Dentures/Crown dates:_______________________________

Oral Surgeries:______________________________________

Tooth Sensitivities:_________________________________

Wisdom Teeth:
Intact Removed Failed to Form

Based on the diagram below, enter the tooth number(s) for all teeth with:
Fillings:
Root canals:
Sore teeth:
Areas of concern:



FEEL FREE TO USE THIS SPACE TO RECORD ANY ADDITIONAL INFORMATION YOU THINK SUMMER NEEDS TO KNOW:

SEX/GENDER SPECIFIC HISTORY

WOMEN'S HEALTH

PMS symptoms
Irregular/missed periods
Painful periods
Short cycles (<26 days)
Long cycles (>35 days)
Clots in menstrual blood
Fatigue after menses
Spotting between periods

Date of last period___________

 # Days of bleeding __________

Color of blood:

bright dark pale

Type of blood:

light medium heavy

Vaginal discharge
Vaginal infections
Uterine fibroids
Endometriosis
Ovarian Cyst
Hysterectomy, when:

Current or past sexual or physical abuse
Sexually transmitted disease(s)
Pain with intercourse
Difficulty conceiving
Pregnant now or trying to get pregnant

Current method of birth control:

____

Past methods of birth control:

____

__# of Pregnancies

__# of Births

__# of Miscarriages

__# of Abortions

Note any complications during pregnancies, births, postpartum:

Breast fibroids
Breast lumps
Breast pain
Nipple discharge

Monthly breast exam? Yes No

Last Pap Smear:

____

Last mammogram or thermograph:

____

(Note: Summer does not recommend mammograms based only on age)

Cancer:
ovarian uterine
breast cervical
Menopause symptoms
Hormone Replacement Therapy
Decreased sexual energy
Increased sexual energy

MEN'S HEALTH

Prostate hypertrophy (BPH)
Testicular pain/swelling
Difficulty conceiving
Penile discharge
Cancer
Prostate Testicular Breast

Increased sexual energy
Decreased sexual energy
Sexual difficulties
Current past sexual or physical abuse
Sexually transmitted diseases

Thank you for providing us with your valuable health information. Taking the time to do a thorough health history is one of the first steps to reclaiming your health. If your health history changes from visit to visit, it is important to inform your provider.