

Veronica Waks, ND

Patient Information Form

Name of Patient _____ Sex _____ Age _____

Referred to Dr. Waks by _____

Mailing Address _____ City _____

State _____ Zip Code _____ Email Address _____

Home Phone _____ Cell Phone _____ Work Phone _____

Birthdate ____/____/____

Occupation _____ Full Time Y/N

Marital Status (S) (M) (D) (W)

Spouse/Partner/Parent _____

That person's phone number _____ and Email _____

Current Health Care Team:

Your Primary Care Doctor _____ Dr. Phone Number _____

Specialist Doctor _____ Dr. Phone Number _____

Specialist Doctor _____ Dr. Phone Number _____

Specialist Doctor _____ Dr. Phone Number _____

PATIENT INTAKE FORM

What are your goals for this visit?

Prioritize your most important health concerns today:

	<u>Concern</u>	<u>Onset</u>	<u>Frequency</u>	<u>Severity</u>
	Ex: Headache	June 1978	4 times/week	mild/mod/severe
1.	_____	_____	_____	_____
2.	_____	_____	_____	_____
3.	_____	_____	_____	_____
4.	_____	_____	_____	_____

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What prior experiences have you had with alternative or complementary medicine?

With whom do you live? (include roommates, friends, partner, spouse, children, parents, relatives, pets)

Name	Age	Relationship	Name	Age	Relationship
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_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____
_____	_____	_____	_____	_____	_____

What are the major stresses in your life?

What do you do to relax/relieve stress? What interests/hobbies do you have?

Occupation – current: _____

Occupation – past: _____

Spiritual beliefs/religious affiliations – past and present:

HEALTH HABITS

What physical activity do you participate in, and how often?

Energy level: _____

Describe your sleep pattern: _____

Nutrition

How many meals do you generally eat per day? _____ Do you skip meals? _____

How many servings of fruit per day? (Svg: 1 medium fruit) _____

How many servings of vegetables do you consume each day? (Svg: 1 C raw, ½ C cooked) _____

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Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian? Please explain.

What are your sources of protein? _____

What type of oil or spreads do you add to your food? _____

What and how much do you drink on a typical day? (i.e. water, filtered or not?, caffeine drinks, soda)

How would you describe your relationship with food?

How often do you eat out? _____ Who prepares the meals at home? _____

Tobacco use – note current or past use

Type: _____

Amount per day (or week): _____

Recreational drugs – note current or past use

Type: _____

Amount per day (or week/month): _____

Alcohol – note current or past use

Type: _____

Amount per day (or week/month): _____

Have you ever had to cut down on your drinking? _____ Yes _____ No

Do you get annoyed when someone asks about your drinking? _____ Yes _____ No

Do you ever feel guilty about your drinking? _____ Yes _____ No

Do you ever have to make excuses for drinking or for your behavior while drinking? _____ Yes _____ No

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Date of last pap _____ History of abnormal paps? _____

Number of: Pregnancies _____ Live Births _____ Abortions _____ Miscarriages _____

Have you experienced complications during pregnancy/delivery/other problems?

Contraceptive History

Please circle the method of contraception you are currently using:

Birth Control Pills Type _____ Total Years of Use _____

Diaphragm/Cap Type _____ Size _____

IUD Type _____ Date of Last Change _____

Norplant Condom and/or Foam, Suppository Tubal Ligation

Hysterectomy (date: _____) Partner with vasectomy None

Other _____

Problems with current method _____

MEN ONLY:

Do you have: _____ Prostate Problems _____ Testicular Cancer _____ Vasectomy
 _____ Sexual Dysfunction _____ Other (specify _____)

MEDICATIONS

What medications are you taking now? (Include prescription and over-the-counter drugs.)

Medication	Reason	When Started	Dosage Per Day	Cost
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

Are you allergic/have you had a bad reaction to any medications to other substances? ____ Yes ____ No
If yes, please specify drug(s) and type of reaction: _____

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What vitamins/minerals/herbal supplements are you taking now?

Supplement + Brand	Reason	When Started	Dosage Per Day	Cost
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____
_____	_____	_____	_____	_____

FAMILY MEDICAL HISTORY

Who in your immediate family has any of the following? Place appropriate letter in blank.
(F=Father, M=Mother, S=Sibling, G=Grandparent)

- | | |
|-------------------------------------|---|
| _____ Alcoholism or Substance Abuse | _____ High Cholesterol |
| _____ Anemia | _____ Kidney Disease |
| _____ Arthritis | _____ Liver Disease |
| _____ Cancer | _____ Lung Disease |
| Type: _____ | _____ Mental Trouble/Depression/Anxiety |
| _____ Diabetes | _____ Seizure, Epilepsy |
| _____ Digestive Disorder | _____ Stroke |
| _____ Easy Bleeding | _____ Suicide |
| _____ Glaucoma | _____ Thyroid Disease |
| _____ High Blood Pressure | _____ Tuberculosis |
| _____ Hay Fever, Allergy, Eczema | _____ Ulcers |
| _____ Headaches | _____ Osteoporosis |
| _____ Heart Disease | _____ Other: _____ |
| | _____ Other: _____ |

PAST PSYCHOTHERAPY

Have you seen a psychotherapist in the past? _____ Yes _____ No

If so, please explain: _____

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REVIEW OF SYSTEMS: Please circle what applies and describe extra details:

Skin: new moles, cuts that don't heal, easy bruising, cellulite, varicose veins, rashes, other

Hair: bleached or dyed, falling out, thinning, dandruff, other **Nails:** cracking, too soft, thin, ridges, white spots, other

Head: aches, bumps, dizzy, fainting, numbness in face or jaw, other

Eyes: changes in vision, blurred or double vision, spots, pain, floaters, bright lights/lines, other

Ears: ringing, loss of hearing, balance, wax accumulation, other

Mouth: mercury fillings, other metals in mouth, tongue cracks, bad breath, bleeding gums, dentures

Nose: bleeding, running, stuffy, sinus problems, decreased sense of smell, other

Digestive problems: bloating, gas, heartburn, nausea, vomiting, cramping, reflux, other

Lymph nodes: swollen, painful, other

Joints: swollen, painful, replacements, other

Heart: hypertension, irregular rhythms, skipped beats, chest pain, other

Lungs: wheezing, cough, short of breath, work around chemicals, allergies, other

Urogenital: blood in urine, pain or trouble with urination, sexual dysfunction, other

Infectious Diseases: pink eye, candida, herpes, chlamydia, gonorrhea, AIDS, other

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Please feel free to use the remaining space to discuss anything else you wish me to know about your life, health, emotions, the kind of person you are, goals, concerns, etc. Thank you for taking the time to complete this intake form.