**Healing Path**
**Integrative Medicine, PLLC**
**Anne Walch, MHS, PA-C**

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# New Patient Intake Form

Thanks in advance for completing this with care. I will read it. If not enough space is provided below, please add on another sheet – typed appreciated.
If you have had a long and/or complex illness please make a timeline including: age/year; symptoms; doctors (name and type) seen; tests/labs performed, their results; treatment specifics and outcome of treatment.

Patient name _____ Date _____ Age _____

Reason for visit (In brief, your top concerns and what you hope to get from this consult):

Other issues:

If applicable, when did you last feel really well for a sustainable period? (age/year)

How would you rate your overall level of health; **0** being "worst possible" , and **100** is "great, no problems whatsoever": Physical _____/100 Mental health _____/100.

Marital status (circle): single | married | divorced | widowed | partnered | engaged

Where do you live (city/state):

now _____
and as child _____
young adult _____
adult _____

Have you had foreign travel? Where/when, especially if to developing country?

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## *Review of your health systems*

Weight (circle): stable | going up | going down

Ideal weight: _____ Highest adult weight: _____ Lowest adult weight: _____

Appetite (circle): normal | low | high

Energy level (0%--------to ------100% of "optimum") at worst: ___/100 at best: ____/100

Better in morning, afternoon, or evening?

Worse in morning, afternoon, evening, all the time ?

| | | | |
|---|---|---|---|
| Do you sleep through the night? | Yes \| No | Go to bed with pain? | Yes \| No |
| Difficulty falling asleep? | Yes \| No | Snore? | Yes \| No |
| Wake up early? | Yes \| No | Gasp? | Yes \| No |
| Feel refreshed upon waking? | Yes \| No | Sleep study? | Yes \| No |

Constitutional (circle all that apply) fever | chills | sweats

Regarding the next long section, please circle (Y = YES) if you have the problem NOW, and/or (P = PAST) if you've had in the past. If you don't have the problem cross thru or leave blank.

### Skin

| | | | | | |
|---|---|---|---|---|---|
| Rashes | Y P | Acne | Y P | Skin Cancer | Y P |
| Hives | Y P | Dry | Y P | Hair Loss | Y P |
| Eczema | Y P | Excessive sweating | Y P | Change in hair texture | Y P |
| Psoriasis | Y P | Change in Mole | Y P | Change in Nails | Y P |

### Eyes

| | | | | | |
|---|---|---|---|---|---|
| Change of vision | Y P | Blurred | Y P | Eye pains | Y P |
| Floaters | Y P | Cataracts | Y P | | |
| Double vision | Y P | Lasik eye surgery | Y P | | |

### Ears, Nose

| | | | | | |
|---|---|---|---|---|---|
| Ringing | Y P | Sinus infections | Y P | Nosebleeds | Y P |
| Change in Hearing | Y P | Chronic congestion | Y P | Post Nasal Drip | Y P |
| Ear pain | Y P | Nasal Polyps | Y P | Seasonal Allergies | Y P |

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## Mouth and Throat

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Gum Disease | Y | P | Swollen glands | Y | P | Choking | Y | P |
| Dry Mouth | Y | P | Hoarseness | Y | P | Trouble Swallowing | Y | P |
| Frequent sore throats | Y | P | Root canals | Y | P | Teeth Pain | Y | P |
| Canker sores | Y | P | Amalgam fillings removed | Y | P | | | |
| Cold Sores | Y | P | Dry mouth | Y | P | | | |

## Chest

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Cough | Y | P | Air Hunger | Y | P | Pain with breathing | Y | P |
| Short of breath | Y | P | Asthma | Y | P | | | |

## Heart

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| High blood pressure | Y | P | Pounding | Y | P | Lightheaded | Y | P |
| Low blood pressure | Y | P | Chest pain | Y | P | Raynaud's | Y | P |
| Palpitations | Y | P | Heart murmur | Y | P | | | |
| Racing | Y | P | Arrhythmias | Y | P | | | |

*If you have had these, indicate when, and what were the results?*

| | |
|---|---|
| EKG? | Stress Test? |
| Echocardiogram? | Tilt table? |

## Gastrointestinal

| | | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|---|
| Gas | Y | P | Indigestion/reflux | Y | P | Crohns | Y | P |
| Bloating | Y | P | Hemorrhoids | Y | P | Ulcerative colitis | Y | P |
| Pains | Y | P | Rectal Itching | Y | P | Irritable Bowel | Y | P |
| Nausea | Y | P | Rectal burning | Y | P | Constipation/ Diarrhea | Y | P |
| Vomit | Y | P | Gallbladder disease | Y | P | | | |

How often do you have a bowel movement? _____

Any change in bowel movement?_____

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## Urinary Tract

Incontinence Y P | Difficulty passing stream Y P | Kidney stones Y P

Urgency Y P | Blood Y P

Urinary tract infections Y P If yes, when was last infection _____

If you are up a night to urinate, how many times? _____

## Male Reproductive

Genital Pain Y P | Sexually Active Y P | STD's Y P

Hernia Y P | Lowered Desire Y P | Prostate problems Y P

Discharge Y P | Less Erections Y P | Do you do self testicular exams Y P

## Female Reproductive

Last menstrual bleed _____ Age periods began _____ Last Pap_____

Any abnormal _____

Times pregnant _____ How many births _____ Miscarriages # _____ Abortion #_____

Sexually active Y P

Is sex drive low | normal | high? Any problems with sexual functioning? Y P

Vaginal dryness/itching Y P

Pain with intercourse Y P NA | Vaginal/pelvic pains Y P

Vaginitis Y P | STD's Y P

If so, which ones and last occurrence _____

If applicable: Periods come every _____ days/weeks ; periods last _____days

Menstrual cramping Y P | Heavy bleeding Y P

PMS Y P

What forms of birth control do you currently use and what forms have you used in the past?

Do you perform self breast exam every month? Yes | No | Sometimes

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## Joints/ Muscles/Bones

Pains? Y P If so, where _____
Swelling Y P
Redness Y P
Warmth Y P
Cramps Y P
Stiffness Y P If so, where _____

## Nervous System

| | | |
|---|---|---|
| Headaches | Y P | If so, describe quality, location, frequency: |
| Migraines | Y P | If so, describe quality, location, frequency: |
| Seizure | Y P | |
| Involuntary Movements | Y P | If so, describe: |
| Balance issues | Y P | |
| Vertigo | Y P | |
| Memory issues? | Y P | |
| Any changes in concentration, focusing, learning new information? Any sensitivity to light, sound, smells? | Y P | If yes, describe: |
| Twitching, burning, numbness or abnormal sensations? | Y P | Where: |
| Tremor | Y P | |
| Stabbing pains | Y P | |
| Limb/Muscular weakness | Y P | |
| Easy startle | Y P | |
| Slur | Y P | |
| Other weird sensations | Y P | If yes, describe: |

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## Mental/Emotional

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Depression | Y | P | Fear / Panic Attacks | Y | P | Low stress tolerance | Y | P |
| Moody | Y | P | Paranoia | Y | P | Psychiatric Hospitalizaiton | Y | P |
| Irritable | Y | P | Hallucinations | Y | P | Eating disorder | Y | P |
| Anxious | Y | P | Suicidal | Y | P | | | |

## Dates for most recent:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Eye exam | _____ | Dental visit | _____ | Bloodwork* | _____ | Doctor visit* | _____ |
| Pap* | _____ | Mammogram* | _____ | Thermogram* | _____ | Breast Exam | _____ |
| Colonoscopy* | _____ | Bone Density* | _____ | Rectal exam | _____ | Prostate exam | _____ |
| PSA test* | _____ | MRI* | _____ | CT scan* | _____ | Ultrasounds* | _____ |

**Please bring copies of the results.*

Any significant allergy or intolerance to any medication or supplement or substance? And what was the reaction? And when?

Please list any current medications and dosages and frequency of use (Please type on separate sheet if you need more space):

Please list any current supplements used regularly, dosage and frequency (Please type on separate sheet if you need more space):

## Social

What education if any beyond high school:

What kind of work have you done or are doing (occupation):

Hours worked per week? _____

Do you enjoy your work? _____

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What are your major sources of stress?

Do you feel supported (circle one)? Strongly | Fair | Barely

If so, by whom? what?

Does your life have meaning, purpose?

With whom do you live?

Your hobbies, interests, passions, delights:

Do you have animal companions? (Circle one) Indoors | Outdoor | Both

## Habits

Regarding the use of the following, do you currently use? Y=Yes, N=No, P=Past
Cigarette/Cigar Y N P How long? _____ How many per day? _____
Chewing Tobacco Y N P How long? _____ How many per day? _____
Second-hand smoke exposure? Y N P
Caffeine Y N P What form (circle all that apply): tea | coffee | chocolate | mate)? How many per day? ____
Artificial Sweeteners (Splenda, NutraSweet, Equal, saccharin) Y N P Number per day _____

Alcohol Y N P Number, type, frequency of use:

Laxatives Y N P Type, frequency of use:

OTC Analgesic Y N P Type, frequency of use:

Antacids Y N P Type, frequency of use:

Drug Addiction Y N P Type, frequency of use, any drug treatment:

Do you exercise Y N P Type, frequency and minutes/day:

Do you practice forgiveness? Gratitude? Y N

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## Diet

*How would you describe your diet:*

Standard American?

On-the-run?

Horrible?

Pretty good?

Vegan?

Veggie?

Mostly organic?

Gluten-free?

Known food allergies:

Circle any that apply: Skip breakfast | crave sugar | crave salt

How often do you eat out?

Which restaurants do you favor?

*List a typical day's diet:*

| |
|---|
| Breakfast |
| Lunch |
| Dinner |
| Snacks |
| Beverages |

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## *Your Medical History*

## Childhood

What if any issues did you have (circle)? Bottle-fed , breast-fed, both ; colic , eczema , asthma , ear infections , recurrent colds , bedwetting , polio , seasonal allergies , food allergies , pneumonia , bronchitis , tonsillectomy , learning disability , attention deficit , depression , anxiety , other_____
Was your childhood home life (circle appropriate terms): loving, supportive , stressful, abusive , peaceful , loud, argumentative , educational , alcoholic, friendly, single-parent , lonely , numerous siblings , other:

Did you receive the normal series of childhood vaccines? Yes / No

When were your last vaccines and what type if you remember?

Please list any current or prior medical or psychiatric diagnoses and approximate age/year of onset:

Please list all surgeries and approximate age & date:

Please list all hospitalizations or ER visits, age& date and reason (excluding surgery):

Have you had any tick attachments? If so when? Was there an obvious resulting illness? Were you treated? If so, with what and for how long?

Please advise of exposure to physical toxicities -- example: mold, lead (stain glass, home renovation), mercury (amalgams, thermometers), pesticides/herbicides, radiation, plug-in air "fresheners", second-hand smoke, incense, solvents, other chemicals?

Please advise of any traumas you have endured and when --Might be physical, emotional, psychic, etc (or consider sharing at a later time):

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## Family health

# of siblings:_____biological_____adopted / half_____
# of children:_____biological_____adopted / half_____
Father Mother Siblings Grandparents Spouse Children

| | Father | Mother | Siblings | Grandparents | Spouse | Children |
|---|---|---|---|---|---|---|
| **Ages if living** | | | | | | |
| **Ages at death** | | | | | | |
| **Reason for death** | | | | | | |
| **High Blood Pressure** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Heart Attack/Stroke** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Heart disease** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Asthma/Allergy** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Mental Illness** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Auto-Immune** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Hypothyroid** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Neurological** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Diabetes** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Obesity** | Y N | Y N | Y N | Y N | Y N | Y N |
| **Other** | | | | | | |

Please list the names of any doctors, specialists, chiropractors, acupuncturists, therapist, counselors, etc who you have seen in regard to the health issues you are experiencing:

| Name | Dates Seen | Type of Practitioner |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |