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New Patient Intake Form

Today's Date: _____

Name: _____ Age: _____
 (Last) (First) (MI)

Date of Birth: _____ Sex: M____ F____ Blood Type: _____ (+ or --)

Contact Information

Address: _____
 (Street) (City) (State) (Zip)

Home Phone: _____ Business Phone: _____

Cell Phone: _____ E-mail: _____

How do you prefer to be contacted? Home Work Cell E-mail

May we leave a message? Home Work Cell E-mail

Emergency contact: _____
 (Name, relationship, day & evening telephone)

How did you hear about our clinic? _____

Your Healthcare Providers

Primary Care Physician: _____
 (Name & Address)

Date of Last Physical Exam: _____
 (Month & Year)

Screening Test/Evaluation	Date of Most Recent
Cholesterol test	
Breast exam & self care	
Mammogram/Ultrasound	
Pelvic Exam/Pap test	
Prostate	
Colorectal Exam	
Urinalysis	
Hearing Evaluation	
Vision Test/Eye Exam	
Routine bloodwork/screen	
Other	

Are you currently under the care of a specialist? Yes No

1) _____
 (Name/Specialty/Address)

2) _____
 (Name/Specialty /Address)

3) _____
 (Name/Specialty/Address)

Allergies/Adverse Reactions to Medications & Substances

Please describe any adverse or allergic reactions that you have had to any of the following: prescription drugs, over-the-counter-medications, recreational drugs, vaccinations, herbs, vitamins, minerals or homeopathics

Name of substance	Describe the reaction

Environmental/Food Allergies & Sensitivities (food, pollen, mold, animals, chemicals)

Name of allergen	Describe the reaction

Please check box at right if you have ever been treated with or used any of the following:

Antibiotics for > 2 weeks	<input type="checkbox"/>	Antacids	<input type="checkbox"/>
Cortisone/other steroids	<input type="checkbox"/>	Chemotherapy/radiation	<input type="checkbox"/>
Antihistamines	<input type="checkbox"/>	Pain relievers	<input type="checkbox"/>
Arthritis drugs (Vioxx, Celebrex)	<input type="checkbox"/>	Hormone therapy	<input type="checkbox"/>
Thyroid medication	<input type="checkbox"/>	Recreational drugs	<input type="checkbox"/>
Laxatives/stool softeners	<input type="checkbox"/>	Blood thinners	<input type="checkbox"/>
Anti-depressants	<input type="checkbox"/>	Stimulants	<input type="checkbox"/>
Flu vaccine	<input type="checkbox"/>	Diuretics	<input type="checkbox"/>
Vaccine for foreign travel	<input type="checkbox"/>	Anesthesia	<input type="checkbox"/>
Sleeping pills/sedatives	<input type="checkbox"/>	Epidural	<input type="checkbox"/>

Toxin Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes, or other toxic substances at home, at work, or while traveling?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations, or having your lawn sprayed?	<input type="checkbox"/>	<input type="checkbox"/>
Are you particularly sensitive to perfume, gasoline, or other vapors?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever lived near a refinery or polluted area?	<input type="checkbox"/>	<input type="checkbox"/>
Have you ever lived in a home more than 50 years old?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have mercury dental fillings?	<input type="checkbox"/>	<input type="checkbox"/>
Have you had any dental root canal procedures?	<input type="checkbox"/>	<input type="checkbox"/>
Do you have any surgical implants or prosthesis (cosmetic or medical)	<input type="checkbox"/>	<input type="checkbox"/>
Do you live near power lines?	<input type="checkbox"/>	<input type="checkbox"/>

Surgeries

Procedure	Year	Any complications?

Hospitalizations/Major Injuries or Trauma

Reason/Injury	Year	Outcome

Family History

	Father	Mother	Brothers	Sisters	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (good, avg. poor)	_____	_____	_____	_____	_____	_____
Deceased age	_____	_____	_____	_____	_____	_____
Cause of death	_____	_____	_____	_____	_____	_____
Check those applicable:						
Allergies	_____	_____	_____	_____	_____	_____
Alcohol/drug abuse	_____	_____	_____	_____	_____	_____
Anemia	_____	_____	_____	_____	_____	_____
Arthritis (OA/RA)	_____	_____	_____	_____	_____	_____
Autoimmune Dz.	_____	_____	_____	_____	_____	_____
Alzheimer's Dz	_____	_____	_____	_____	_____	_____
Cancer (specify type)	_____	_____	_____	_____	_____	_____
Diabetes	_____	_____	_____	_____	_____	_____
Epilepsy/Seizures	_____	_____	_____	_____	_____	_____
Hepatitis	_____	_____	_____	_____	_____	_____
Kidney Disease	_____	_____	_____	_____	_____	_____
High Blood Pressure	_____	_____	_____	_____	_____	_____
Stroke	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Obesity	_____	_____	_____	_____	_____	_____
Osteoporosis	_____	_____	_____	_____	_____	_____
Thyroid Condition	_____	_____	_____	_____	_____	_____
Skin Conditions	_____	_____	_____	_____	_____	_____
Depression	_____	_____	_____	_____	_____	_____
Mental Illness	_____	_____	_____	_____	_____	_____
Heart disease	_____	_____	_____	_____	_____	_____
Neurological disease	_____	_____	_____	_____	_____	_____
Tuberculosis	_____	_____	_____	_____	_____	_____
Syphilis	_____	_____	_____	_____	_____	_____
Gonorrhea	_____	_____	_____	_____	_____	_____
Asthma	_____	_____	_____	_____	_____	_____
Gout	_____	_____	_____	_____	_____	_____
Other (specify)	_____	_____	_____	_____	_____	_____

Past Medical History *(Please check if you have had any of the following childhood illnesses)*

_____ Chickenpox	_____ Coxsackie	_____ Diphtheria	_____ Fifth's	_____ Measles
_____ German measles	_____ Mono	_____ Mumps	_____ Polio	_____ Rheumatic Fever
_____ Rotovirus	_____ Smallpox	_____ Typhoid	_____ TB	_____ Whooping Cough

Medical Conditions *(for any of the following, please mark {P} for past or {C} for current)*

_____ Allergies	_____ Lung Disease
_____ Anemia	_____ Mononucleosis
_____ Asthma	_____ Pneumonia
_____ Autoimmune	_____ Seizures
_____ Cancer	_____ Substance Abuse
_____ Canker sores	_____ Stroke
_____ Chronic fatigue	_____ Syphilis
_____ Chronic infections	_____ Tonsillitis
_____ Depression	_____ Ulcers
_____ Anxiety	_____ Venereal diseases/STDs
_____ Diabetes	_____ Significant weight changes
_____ Ear infections	_____ Joint Problems
_____ Eating Disorder	_____ Other (please describe)
_____ Eczema	
_____ Fracture	
_____ Glaucoma	
_____ Heart Disease	
_____ Herpes	

- Hepatitis
- High Blood Pressure
- HIV +/-AIDS
- Irritable Bowel Syndrome

Current Health Factors

Which best describes your general state of health: Excellent Good Average Fair Poor
 What time of day do you feel most energetic? _____ least energetic? _____

List 5 important events in your life from most recent to the most distant.

- 1) _____ Date: _____
- 2) _____ Date: _____
- 3) _____ Date: _____
- 4) _____ Date: _____
- 5) _____ Date: _____

Which of these events has affected you most and why? _____

Rate your current stress level with each of the following (1 = least stressful and 10 = most stressful)

- Family Spirituality Other relationships
- Work/School Physical health Sense of self-fulfillment/purpose
- Love relationship Mental health

Are you currently under the care of a professional counselor, social worker, psychologist, religious counselor, or other type of therapist? yes no

Review of Systems

Please check space to the left if you have experienced or are currently experiencing any of the following. Please mark (P) for past and (C) for current.

Mental/Emotional

- Abuse Memory problems
- Anxiety/nervousness Mental Illness
- Depression Mood swings
- Easily angered Panic attacks
- Indecision Phobias
- Irritability Prolonged sadness or grief

Has there been an event or illness that you have never fully recovered from?

Endocrine System

- Significant change in weight Generally feel hot
- Sluggish after eating Generally feel cold
- Poor concentration Hypoglycemia (low blood sugar)
- Sluggish after coffee/stimulants Mental dullness

Rate your energy level (1= extreme fatigue, 10 = abundant energy) _____

Rate your stress level (1= relaxed, 10 = extremely stressed) _____

How many hours of sleep do you get per night, on average? _____

Do you wake feeling rested? _____

Immune System

- Chronic infections Cold sores Slow wound healing
- Frequent use of antibiotics Swollen glands or lymph nodes Frequent sore throat
- Frequent colds/flu Shingles

Neurologic

- Paralysis Tingling/pins & needles Vertigo/dizziness
- Numbness Loss of memory
- Muscle weakness Loss of balance

Skin, Hair & Nails

- Rashes
- Lumps or abscesses
- Dry skin
- Night Sweats
- Itching
- Excessive sweating
- Change in size, shape, or color of mole or freckle
- Brittle nails
- Hair loss
- Change in skin color
- Warts
- Night sweats
- Strong body odor

Do you have a history of severe sunburns/frequent tanning? _____

Head, Ears, Eyes, Nose, & Throat

- Headaches
- Cataracts
- Nose bleeds
- Gum disease
- Night blindness
- Loss of smell
- Migraine
- Visual disturbances
- Ringing in ears
- Poor sense of smell
- Hoarseness
- Itchy ear canal
- Far-sightedness
- Near-sightedness
- Jaw pain/clicking
- Excessive tearing
- Earaches
- Post-nasal drip
- Teeth grinding
- Runny nose
- Dry eyes
- Impaired hearing

Respiratory System

- Chronic cough
- Shortness of breath when lying down
- Pain while breathing
- Chronic phlegm
- Coughing up blood
- Wheezing
- Shortness of breath during the day

Cardiovascular System

- Chest pain
- Hemorrhoids
- Dizzy when standing up quickly
- Varicose veins
- Fainting
- Heart palpitations
- Easy bruising or bleeding
- Heart murmurs
- Cold hands & feet
- Socks leave an imprint on your ankles
- Heaviness or pain in the legs

Gastrointestinal System

- Trouble swallowing
- Nausea
- Blood in stool or on tissue
- Constipation
- Stool floats in bowl
- Hard stool
- Heartburn
- Bloating
- Stomach cramps or pain
- Diarrhea/loose stool
- Itching around rectum
- Grey stool
- Change in thirst
- Gas
- Black stool
- Change in appetite
- Burping
- Mucous in stool
- Undigested food in stool

Bowel Movement Habits:

Frequency (how often): Every day Every other day Every week
 Color: Dark Brown Green Yellow White Gray
 Consistency: Soft Hard Watery
 Other: Mucus Blood (circle: bright or dark) Strong Odor

Have you ever traveled to a third-world country? _____

Have you ever had a parasite that you are aware of?

Urological System

- Pain on urination
- Frequent bladder infections
- Strong urine odor
- Kidney stones
- Inability to hold urine
- Kidney infections
- Awaken to urinate
- Must strain to urinate
- Pain on urination
- Increased frequency

Male Reproductive

- Hernia
- Discharge or sores
- Low sex drive
- Testicular mass
- Testicular pain
- Prostate condition
- Sexual difficulty
- Impotence

What is your sexual orientation?: heterosexual homosexual bisexual

Are you sexually active? _____

Do you practice protected sex? _____

When was your last prostate exam? _____

Female Reproductive

Age of first menses _____

Age of last menses _____

How long is your cycle (in days)? _____

How would you describe your menstrual flow? ___ normal ___ light ___ heavy
Do you use tampons? _____

How many days is your menses? _____
Number of pregnancies _____
Are you currently pregnant? _____
Are you trying to conceive? _____

What type of birth control do you use (if any)? _____
What is your sexual orientation?: ___ heterosexual ___ homosexual ___ bisexual
Are you sexually active? _____
Do you practice protected sex? _____

Gynecological Health

___ Excessive discharge	___ Abnormal pap tests	___ Pain during intercourse
___ Itching	___ Sexual difficulties	___ Menopausal symptoms
___ Abdominal pain mid-cycle	___ Sores, growths, lumps	___ Low sex drive
___ Vaginal dryness	___ Odor	___ History of miscarriages
		___ History of abortion

Pre-menstrual and Menstrual Symptoms

___ Pain or cramping	___ Irregular cycles	___ Heavy flow
___ Flow more than 5 days	___ Flow less than 5 days	___ Light flow
___ Diarrhea	___ Bloating	___ Bleeding between periods
___ Water retention	___ Breast tenderness	___ Cravings
___ Clotting	___ Missed periods	___ Mood swings
___ Headaches	___ Low back ache	

Breast Health

___ Fibrocystic breasts	___ Nipple discharge	___ Flaky dry skin on the nipple
___ Puckering of skin	___ Tenderness	___ Breast lump or mass

Do you perform monthly self-breast exams? Yes No
When was your last breast exam? _____
Do you have regular mammograms? _____
Do you have a family history of breast cancer? _____

Lifestyle

Have you ever been a smoker? If yes, how many packs per day and for how long?

Do you currently smoke? Yes No
Are you exposed to or do you have a history of exposure to secondhand smoke?

How often do you drink alcohol and how much do you drink?

Do you currently use recreational drugs?

Any history of recreational drug use? _____

How often do you exercise? _____
What type of exercise do you do? _____

What do you do to relax? _____
Do you feel like you have a strong social support network? _____
Describe your living situation _____
Do you have any pets? _____
Do you feel safe at home? ___ Yes ___ No
Do you have a history of physical or sexual abuse? ___ Yes ___ No
Do you have a spiritual practice? _____

Diet

What type of water do you drink? _____
How much water do you drink per day? _____

How many times per week do you eat dairy products? _____
How many times per week do you eat red meat? _____
How many times per week do you eat fish? _____
How many times per week do you eat poultry? _____
How many times per week do you eat fruit? _____
How many times per week do you eat vegetables? _____

Do you eat organic food? Yes No
How often do you eat out? _____
What foods do you crave? _____

How many sodas/coffees/ teas do you drink per week? _____
Do you eat smoked foods? Yes No
Do you have any dietary restrictions? (vegetarian, vegan, religious, or
allergy) _____

Other

How does your general state of health affect you? _____
What do you feel needs to happen for you to get better?

What do you enjoy most in your life?

How much change are you willing to make at this time for improving your health?
MINIMAL SOME COMPLETE

Is there any information about your health that you would like to add?

Thank you for taking the time to fill this out. We look forward to meeting you!