Initial Visit Intake Form

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Name____ Email _________________________
Address______________________________City_____________ State _____ Zip____________
Phone Home____________________ Cell ____________________ Work __________________
Age______ Birth date___/___/___ Male/ Female/ Other Height______Weight_______
Color Hair_________ Eyes____________ Ethnicity/ Nationality _________________________
Emergency Contact (Name/ Address/ Phone) ____
Referred by____

What are your current primary health concerns:

Current Symptoms	Date of onset	Circle one
___________________________	____/____/____	Gradual/ Abrupt
___________________________	____/____/____	Gradual/ Abrupt
___________________________	____/____/____	Gradual/ Abrupt
___________________________	____/____/____	Gradual/ Abrupt
___________________________	____/____/____	Gradual/ Abrupt

What kind of care are you seeking now? Practitioners/ Doctors

Western and other Diagnosis?

In order to heal the condition are you willing to make changes to your lifestyle?
Describe how your present condition affects you in relation to your:
Work ____
Family ____
Friends ____
Social Lifestyle:
Martial Status: Single___ Partnered ___ Married (#)___ Separated ___ Divorced (#)___ Widowed____
Spouse's Name and Age:____
Spouse's Education/ Occupation: ____
What do you share in common? ____
Children (Name, Age, Health)____
____
Occupation__________________ How long? _________ Education______________________
Do you like your work? ________ Why?____
Religion _____________________________ Are you actively participating? YES/ NO
Organizations? ____
Social Activities/ Hobbies____
Exercise (Kind/ How much daily, weekly, monthly?)___________________________________
How healthy and happy do you expect you should be? (Rate from 0-100%) _________________
How healthy and happy are you now? (Rate from 0-100%) ______________________________
What do you consider to be your most positive attribute? _____________________________

Medical History

Check any diseases, which you or your relatives have had:

Relatives	Arthritis	Cancer	Diabetes	Substance abuse	Gout	Heart disease and /or stroke	High blood pressure	Hypo-thy-roidism	Kidney Disease	Neuro-logical Disease	Peri-odontal Diseases	Athero-sclerosis	Obesity
You													
Father													
Mother													
Brother													
Sisters													
Children													
Maternal Grand-parents													
Paternal Grand-parents													

Circle any other illness that you have or have had in the past:

Acne
Aids
Allergies
Anemia
Anorexia
Back problems
Benign breast tumor
Bronchitis
Bulimia
Candida Albicans
Cataracts
Chicken pox
Cirrhosis
Crohn's Disease
Depression
Diverticulosis
Ear infections
Eczema
Endometriosis
Excessive fatigue
Eye disease
Gallstones gastritis
Gingivitis
Goiter
Gonorrhea
Hay fever
Hemorrhoids
Hepatitis
Hernia
Herniated disc
Herpes
Hives
Kidney stones
Low- blood pressure
Lupus
Malaria
Measles
Mononucleosis
Multiple sclerosis
Mumps
Nervous breakdown
Pancreatitis
Polio
Psoriasis
Rheumatoid arthritis
Scarlet fever
Sciatica
Syphilis
Others____________

Type of Major Surgery/ Hospitilzations	Date	Physician

Circle any of the following medications you are taking now:

Antacids
Antibiotic/Antifungal
Antidepressants
Anti-diabetic/ Insulin
Aspirin/ Tylenol
Chemotherapy
Cortisone/Anti-inflammatory
Cold Medication
Cough Medication
Diet pills
Heart medications
High blood pressure
Hormones
Laxatives
Lithium
Oral contraceptives
Radiation
Recreational drugs
Relaxants
Sleeping pills
Thyroid
Ulcer medications
Others_____

For Anything Circled list:

Name	Dosage	How long have you been taking?

Nutritional History

Name____ Date__________

FOOD TYPE	AGE 0-2	AGE 2-5	AGE 5-13	AGE 13-21	ADULT	PAST YEAR
Fish Meat						
Milk						
Cheese						
Eggs						
Whole grains						
Seeds, nuts						
Fresh fruits						
Fresh vegetables						
Vitamin supplements						
Sweets, soft drinks						
Alcohol						
Tobacco						

Key 0= none (0-2x/mth) 1= occasionally (2-4x/mth) 2= frequently (2-4x/wk) 3= daily (5x/wk or more)

List any vitamins, minerals, self-care materials, herbal remedies, or food supplements you are currently taking.

Item	Dosage	How long used
1		
2		
3		
4		
5		

Check if you eat, drink, or use:

Alcohol
Candy
Carbonated Beverages
Cigarettes
Coffee
Distilled Water
At Fast Food Restaurant
Fried foods
Luncheon meats
Margarine
Refined sugars
Saccharine, Sweet and Low, or Equal
Nutra-sweet

Check if you:

Diet often
Do not exercise regularly
Salt food without tasting
Are under excessive stress
Are exposed to chemicals
Are exposed to cigarette

Medical Symptoms Review

Name: ____ Date: ___________

Directions: Check each symptom that applies in the past month. Circle if important now.

Allergic Reactions:
- Foods
- Inhalants
- Additives
- Hydrocarbons
- Medicines
- Aspirin
- Asthma
- Eczema

Energy Level:
- High
- Low
- Normal

Appetite:
- High
- Low
- Normal

Weight:
- Increased
- Decreased
- Unchanged

Headache:
- Dull
- Sharp
- Stabbing
- Pressure
- Band around head
- One Side

Frequency:
_______ per month

Duration:
__________hours

Location:
- Neck
- Temples
- Forehead
- Eyes
- Back of head
- Jaw
- All over head

Hands usually:
- Warm
- Cold
- Wet
- Dry

Muscles and Bones:
- Leg cramps
- Stiff neck
- Neck pain
- Whiplash
- Wry-neck
- Sore, aching muscles
- Low back pain
- Loss of muscle power
- Swollen joints
- Painful joints
- Arthritis
- Loss of muscle mass
- Tired feet
- Flat feet
- Painful heels
- Tired climbing stairs
- Curvature of spine

Skin:
- Heal slowly
- Bruise easily
- Dry
- Oily
- Red around nose
- Acne
- Boils
- Scaly
- Dandruff
- Itchy
- Red spots
- Brown spots
- Varicose veins
- Scalp hair loss
- Body hair loss
- Seborrhea
- Psoriasis
- Brittle nails
- Eczema
- Excess hair growth

Ears:
- Loss of hearing
- Hearing too sensitive
- Earache
- Motion sickness
- Dizzy
- Noises in ears

Eyes:
- Near-sighted
- Far-sighted
- Astigmatic
- Colorblind
- Painful Eyeballs
- Halo around lights
- Poor night vision
- Glare sensitive
- Inflamed lids
- Sandy feeling in eyes
- Bloodshot
- Seeing double

Nose-throat:
- Sinus trouble
- Post-nasal drip
- Hay fever
- Nosebleed
- Loss of smell
- Strange odors
- Loss of taste
- Metallic taste
- Bad Breath
- Sore throat
- Canker sores
- Change in voice
- Hoarseness
- Lump in throat
- Difficulty swallowing
- Grinding teeth in sleep
- Biting tongue
- Tongue-thrusting

Gums:
- Bleeding
- Infected
- Receding
- Sore

Teeth:
- Toothaches
- Tender to cold
- Cavity-prone
- Soft
- Loose
- Dentures

___ # Extractions

Lips:
- Dry
- Chapped
- Peeling
- Split
- Sores at corners

Tongue:
- Dry
- Sore
- Swollen
- Inflamed
- Split
- Loss of taste

Coated:
- White
- Yellow
- Brown
- Black

Digestive:
- Nausea
- Vomiting
- Belching
- Acidity
- Hepatitis
- Ulcer
- Cramps
- Diarrhea
- Constipation
- Gas
- Thin Stools
- Mucus Stools
- Black Stools
- Gray Stools
- Bloody Stools
- Foul-smelling stools
- Frothy stools
- Rectal spasm
- Hemorrhoids
- Itching Anus

Laxatives:
_____# per month

Enema:
_____# per month

Bowel Movement usually:
_____ # per week

Food Intolerance:
- Wheat
- Milk
- Egg
- Citrus
- Fried foods
- Fats
- Yeast

Chest:
- Cough
- Night sweats
- Painful breathing
- Asthma
- Emphysema
- Bronchitis
- Short of breath
- Green sputum
- Yellow/bloody sputum
- Pleurisy
- Chest pain on exertion
- Irregular pulse
- Rapid pulse
- Palpitation
- Fainting
- Blackout if get up quickly
- Heart murmur
- High blood pressure

Genitourinary:

Frequency:

_____ # per day

_____# per night

- Burning urination
- Loss of control of urination
- Urgency
- Difficulty starting
- Pain in flank/ side
- Kidney stones

Discolored Urine:
- Black
- Brown
- Bloody

Reproductive Systems:
- Loss of sex drive
- Increase in sex drive
- Lack of sexual information or experience
- Hernia
- VD

Women only:

Menstruation _____ days

Cycle __________ days

Pregnancies _____

Miscarriages _____

Abortions _____

Date of last pap smear __________________

- Lack of sexual secretions
- Lack of orgasm
- Vaginal discharge
- Menstrual cramps
- Irregular periods
- PMS

Flow:
- Heavy
- Medium
- Light

Men only:
- Loss of erections
- Premature ejaculation
- Sores on penis
- Pain/ swelling in groin

Sleep:

Need _______ hours

Get ________ hours

- Slow to fall asleep
- Early waking
- Restless
- Disturbing dreams

Spells:
- Anxiety
- Hearth pounding
- Rapid breathing
- Panic
- Weeping
- Depression
- Elation
- Anger
- Nausea
- Irritability
- Poor concentration
- Yawning
- Drowsy
- Trance
- Dizziness
- Misbehavior

Spells continued:
- Memory black-out
- Loss of consciousness
- Convulsion
- Weak
- Shaky
- Chills
- Sweats
- Hot flashes

Spells occur:
- Before meals
- After meals
- If hungry
- If upset
- Morning
- Afternoon
- Evening

Nerves:
- Numbness
- Tingling
- Burning
- Shooting pains
- Weakness
- Dropping things
- Stroke
- Tics
- Change in handwriting
- Change in personality
- Loss of memory
- Inability to concentrate
- Tremor
- Sudden jerks of body or extremities
- Twitch when falling asleep
- Loss of balance
- Clumsiness

Cravings:
- Water
- Sweets
- Salt
- Vinegar
- Citrus
- Meat
- Fat
- Eggs
- Dairy
- Alcohol
- Tobacco
- Bread

Medicines in past months:
- Antibiotics
- Antacids
- Antispasmodics
- Laxatives
- Antihistamines
- Codeine
- Muscle relaxants
- Tranquilizers
- Sedatives
- Sleeping pills
- Antidepressants
- Stimulants
- Diet pills
- Water pills
- Heart pills
- Thyroid
- Cortisone
- Birth control pills
- Female hormones
- Male hormones
- Asthma medications
- Inhalers
- Nasal decongestants
- Pain pills
- Anticonvulsants
- Aspirin
- Chelation therapy
- HCG injection
- B12 injection
- Vitamins
- Minerals
- Other ________________

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Constitutional Intake Form

Names____ Date__________________

Upper GI

- __ Sometimes nausea in mornings
- __ Sometimes nausea in evenings
- __ Sometimes excess salivation
- __ Mouth frequently too dry
- __ Duodenal ulcer
- __ Stomach ulcer
- __ Sometimes foul burps
- __ Butterflies in stomach
- __ Seldom eat breakfast
- __ Often don’t finish meals
- __ Often eat to calm down
- __ Receding gums
- __ Frequent use of alcohol
- __ Frequent poor appetite
- __ Strong, demanding hunger
- __ Bitter taste in morning
- __ “Dragon breath” in morning
- __ Acid indigestion at night
- __ Frequent mouth or cold sores
- __ Sometimes difficulty in swallowing
- __ Indigestion after eating

Lower GI

- __ Stools loose with gas
- __ Constipation with gas
- __ Frequent constipation
- __ Digestion usually rapid
- __ Loose stools when tired/stress
- __ Light colored, hard stools
- __ Dark, soft stools
- __ Quick defecation after eating
- __ Intestines often bloated
- __ Constipation with hemorrhoids
- __ “ with painful defecation
- __ “ with hard, marbly stools
- __ “ with fully formed stools
- __ “ alternate with diarrhea
- __ Frequent need for laxatives
- __ Tongue often coated

Liver

- __ Dry, even scaly skin
- __ Moist, sometimes oily skin
- __ Hives from food or drugs
- __ Hay fever or asthma
- __ Craves proteins, fats
- __ Craves fruits or sweets
- __ Frequent trouble digesting fats
- __ Acne on face AND buttocks
- __ Seems to be low blood sugar
- __ Had hepatitis in past
- __ Frequent use of alcohol
- __ Work with solvents
- __ Psoriasis, eczema, dermatitis
- __ Frequent minor illness
- __ Fever with sweat when sick
- __ Don’t sweat when sick

Renal

- __ Standing too quickly makes pulse roar in ears
- __ Standing too quickly causes faintness/ dizziness
- __ Wakes up at night to urinate
- __ Frequent flushing or blushing
- __ Water retention with change of weather
- __ Moderate high blood pressure, craves fats
- __ Moderate low blood pressure, craves sweets
- __ Frequent thrist
- __ Craving for salt
- __ Urine always light colored
- __ Urine usually darker

Lower Urinary Tract

- __ Frequent urination, small amounts
- __ Infrequent urination, copious
- __ Sometimes dribbles urine afterwards
- __ Frequent bladder infections
- __ Demanding and sudden need to urinate
- __ Mucus in urine
- __ Benign prostatic hypertrophy (males)
- __ Dull ache after urination

Reproductive- all

- __ Sweat freely with strong scent
- __ Oily skin, facial acne
- __ Dry skin, cold hands and feet

Women

- __ Cycle more than 28 days
- __ Cycle less than 28 days
- __ Water retention before menses, hips, breast
- __ Water retention before menses, feet, hands
- __ Craves fats, proteins before menses, usually
- __ Craves sweets before menses, usually
- __ Side of breasts tender before menses
- __ Miss some periods
- __ Menses slow starting with cramps
- __ Palpitations before menses
- __ Menstruation lengthy, frequent cramps
- __ Menstruation short, defined, few cramps
- __ Frequent Class II Pap smears
- __ History of PID, cervicitis
- __ Miscarriages, problem pregnancy
- __ Period early with altitude change
- __ Period late with altitude change
- __ Tried, but couldn’t handle birth control pills
- __ Frequent Candida type infections

Men

- __ Frequent cannabis user
- __ Pain or ache after orgasm
- __ Benign prostatic hypertrophy
- __ Difficult maintaining erection even if you feel in the mood

Respiratory

__ Shortness of breath when standing or walking
__ Tobacco smoker
__ Easy coughing of mucus
__ Difficulty swallowing mucus
__ Rapid, shallow breather
__ Sometimes wake up coughing or gasping for breath
__ Yawns frequently
__ Sometimes hyperventilates
__ Frequent chest colds

Cardiovascular

__ Slow, strong pulse
__ Fast, light pulse
__ Frequent physical activity
__ Warm bodied
__ Cold bodied
__ Sometimes dizzy or faint
__ Hands warm, sweaty
__ Hands cold, clammy or dry
__ Palpitations either as an adolescent or before menses
__ Hypertension, responds to diurectics
__ Hypertension, not responding to diurectics

Lymphatic

__ Recuperates quickly if ill
__ Recuperates slowly if ill
__ Injuries heal quickly
__ Injuries heal slowly
__ Eczema, dermatitis
__ Asthma or hay fever
__ Arthritis or rheumatism
__ Digests fats easily
__ Digests fats poorly

Skin

__ Skin eruptions superficial, come to a head
__ Skin eruptions deep, not coming to a head
__ Skin on trunk is dry
__ Oily scalp or hair
__ Dry scalp or hair
__ Cracks, fissures on heel, feet, slow healing

Mucus

__ Sores, cracks on mouth, anus, vagina
__ Lips often dry, chapped
__ Food often causes intestinal pain passing through
__ Gets sore throat easily

General

Mark conditions that are frequent.
Mark "1" mild condition/ Mark "2" dominant condition

__ Aluminum cooking vessels
__ Awakens, can't go back to sleep
__ Bad dreams
__ Blurred vision
__ Brown spots, bronzing of skin
__ Bruises easily
__ Can't gain weight
__ Can't lose weight
__ Can't get started without coffee
__ Chemical or spray poisoning
__ Chronic fatigue, depression
__ Cry easily without seeming cause
__ Depressed for long periods
__ Earaches
__ Eat often or else faint/nervous
__ Eyes often red, inflamed
__ Face, eyes get puffy
__ Facial twitches
__ Gum problems
__ Headaches
__ Headaches in morning, wearing off
__ Heart palpitations when hungry
__ Heart palpitations after eating
__ Highly emotional
__ Highly controlled
__ Impaired hearing
__ Increase in weight (recent)
__ Lack of sensation somewhere in the body
__ Likes depressants
__ Likes stimulants
__ Lower back pain
__ Frequent muscle cramps
__ Nails split, brittle
__ Nails weak, ridges
__ Nose bleeds frequently
__ Pollution heavy in work or home enviroment
__ Ringing in ears
__ Pulse speeds up after meals
__ Sensitive to cold weather
__ Sensitive to hot weather
__ Sensitive to high humidity
__ Sensitive to low humidity
__ Sexual desire decreased
__ Sexual desire increased
__ Stuffy nose during the day
__ Stuffy nose in evening, night
__ Tendency, seemingly, to anemia
__ Tremors in hands and neck
__ Varicose veins
__ Weight gain in upper arms, shoulders, back of neck

Self Evaluation Form

Name______________________________ Date______________

Circle a number for each item according to your condition this week. Ask yourself: "How much improvement do I need in order to be healthy and happy?"

Answer Key:
0= I need no improvement
1= I need little improvement
2= I need some improvement
3= I need much improvement
4= I need lots of improvement

Job (answer even if unemployed)__________ 0 1 2 3 4
Living quarters__________ 0 1 2 3 4
Spouse or lover (even if you have none)__________ 0 1 2 3 4
Family__________ 0 1 2 3 4
Social Life__________ 0 1 2 3 4
Hobbies__________ 0 1 2 3 4
Sex life (even if abstinent)__________ 0 1 2 3 4
Religion, philosophy, or meaning of life__________ 0 1 2 3 4
Ambition__________ 0 1 2 3 4
Money__________ 0 1 2 3 4 A____
Self-confidence__________ 0 1 2 3 4

General Health__________ 0 1 2 3 4
Physical Energy __________ 0 1 2 3 4
Resistance to infection or ability to heal__________ 0 1 2 3 4
Sleep__________ 0 1 2 3 4
Appetite, digestion, or bowel function__________ 0 1 2 3 4
Skin, lips, gums, or tongue__________ 0 1 2 3 4
Breathing, cough, heart, or blood pressure__________ 0 1 2 3 4
Joints, spine, aches, pains, or headache__________ 0 1 2 3 4
Allergy, hayfever, asthma, or eczema__________ 0 1 2 3 4
Sex function or menstrual function__________ 0 1 2 3 4
Mental concentration ability__________ 0 1 2 3 4
Memory for recent events__________ 0 1 2 3 4 B_____ AB_____

Anxiety or nervousness__________ 0 1 2 3 4
Muscle tension or restlessness__________ 0 1 2 3 4
Indecision__________ 0 1 2 3 4
Worry__________ 0 1 2 3 4
Fear or panic__________ 0 1 2 3 4
Anger or temper outbursts__________ 0 1 2 3 4
Guilt or shame__________ 0 1 2 3 4
Resentment or hostility__________ 0 1 2 3 4
Jealousy or envy__________ 0 1 2 3 4
Loneliness__________ 0 1 2 3 4
Withdrawal from people or seclusivness__________ 0 1 2 3 4
Boredom, or meaningless, or not caring__________ 0 1 2 3 4
Depressed mood or low spirit__________ 0 1 2 3 4
Over-elated mood, too excited or high__________ 0 1 2 3 4
Impulsive behavior or doing before thinking__________ 0 1 2 3 4
Daydreaming__________ 0 1 2 3 4
Putting things off or avoiding goals__________ 0 1 2 3 4
Irritable, jumpy, or easily startled__________ 0 1 2 3 4
Medication dependency__________ 0 1 2 3 4 C_____
Alcohol, tobacco, marijuana, or narcotics (circle) 0 1 2 3 4

Mental confusion__________ 0 1 2 3 4
Mind dulled, slow, or blank__________ 0 1 2 3 4
Thoughts racing or repeating__________ 0 1 2 3 4
Thoughts too loud__________ 0 1 2 3 4
Feeling unreal or strange__________ 0 1 2 3 4
Feeling inferior__________ 0 1 2 3 4
Feeling mistrustful or suspicious__________ 0 1 2 3 4
Feelings deadened, no feelings__________ 0 1 2 3 4
Feelings hopelessness about self or life__________ 0 1 2 3 4
Hearing voices, seeing visions, or hallucinations__________ 0 1 2 3 4 CD_____
Suicidal ideas or self-destructive urges__________ 0 1 2 3 4 Total_____
Homicidal ideas or destructive urges__________ 0 1 2 3 4 D_____

How healthy and happy do you expect you should be? (Rated on a scale of 0-100%)______%
How healthy and happy are you now? (Rated on a scale of 0-100%) __________%

Metabolic Screening Questionnaire

Name____ Date______________

Rate each of the following symptoms based upon your typical health for:
Initial test: the past 90 days
Retest: the past 14 days
Retest: the past 48 hours

Grading of Symptoms:
0 — Never or almost never have the symptom
1 — Occasionally have it, effect is not severe
2 — Occasionally have it, effect is severe
3 — Frequently have it, effect is not severe
4 — Frequently have it, effect is severe

Head
_____ Headaches
_____ Faintness
_____ Dizziness
_____ Insomnia
Total _____

Eyes
_____ Swollen, red, or sticky eyelids
_____ Blurred or tunnel vision
(Not including near or far-sightness)
_____ Bags or dark circles under eyes
_____ Watery or itchy eyes
Total _____

Ears
_____ Itchy ears
_____ Earaches, ear infections
_____ Ringing in ears, hearing loss
_____ Drainage from ears
Total _____

Nose
_____ Stuffy nose
_____ Sinus problems
_____ Sneezing attacks
_____ Excessive mucus formation
_____ Hayfever
Total _____

Mouth, Throat
_____ Gagging, frequent need to clear throat
_____ Sore throat, hoarseness, loss of voice
_____ Swollen or discolored tongue, gums, or lips
_____ Chronic coughing
_____ Canker sores
Total ______

Skin
_____ Acne
_____ Hives, rashes, or dry skin
_____ Hair loss
_____ Flushing or hot flashes
_____ Excessive sweating
Total _____

Heart
_____ Irregular or skipped heartbeat
_____ Rapid or pounding heartbeat
_____ Chest pain
Total _____

Lungs
_____ Chest congestion
_____ Asthma, bronchitis
_____ Shortness of breath
_____ Difficulty breathing
Total _____

Digestive Tract
_____ Nausea or vomiting
_____ Constipation
_____ Bloated feeling
_____ Belching or passing gas
_____ Heartburn
_____ Intestinal or stomach pain
_____ Diarrhea
Total _____

Joints, Muscles
_____ Stiffness or limitation of movement
_____ Pain or aches in muscles
_____ Feeling of weakness or tiredness
_____ Pain or aches in joints
_____ Arthritis
Total _____

Weight
_____ Binge eating, drinking
_____ Craving certain foods
_____ Excessive weight
_____ Compulsive eating
_____ Water retention
_____ Underweight
Total _____

Energy, Activity
_____ Fatigue, sluggishness
_____ Apathy, lethargy
_____ Hyperactivity
_____ Restlessness
Total _____

Mind
_____ Poor memory
_____ Confusion, poor comprehension
_____ Poor concentration
_____ Poor physical co-ordination
_____ Difficulty in making decisions
_____ Stuttering or stammering
_____ Slurred speech
_____ Learning disabilities
Total _____

Emotions
_____ Mood swings
_____ Anxiety, fear, or nervousness
_____ Anger, irritability, or aggressiveness
_____ Depression
Total _____

Other
_____ Frequent or urgent urination
_____ Genital itch or discharge
_____ Frequent illness
Total _____

Grand Total _____

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