Intake Form

General Information

Patient Name			Date
Patient Address	City	State	Zip
Phone Please Specify- Cell Home Work	Email		Contact preference
Gender / Age	DOB	Referred by	

Emergency Contact

Name	Relationship
Phone	Address

Medication and Herb Log

List any medical / food allergies, alerts			
Western medications (& what it is being used for)	Date	Dosage	Frequency
Herbs or Supplements	Date	Dosage	Frequency

Medical History

	You (year)	Family
Cancer (list type)		
Diabetes		
Hepatitis		
High Blood Pressure		
Heart Disease		
Stroke		
Seizure Disorder		
Thyroid Disease		
Asthma		
Pacemaker		
Osteoporosis		
Herpes		
AIDS/HIV		
Other STD		
Rheumatic Fever		
Alcoholism		
Allergies (types)		
Mental Illness		
Kidney Disease		
Anemia		

Social History: Please list the amount and how often each is used

Caffeine	
Nicotine	
Recreational Drugs	
Excessive sugar intake	

Please note any surgeries or significant illnesses that you have or have had in the past.