ENSPIRIT WELLNESS

NEW PATIENT INTAKE PACKET

Name:_____ **Date:**_____

Age:_____

MEDICAL HISTORY: ***PLEASE COMPLETE THE FOLLOWING AS ACCURATELY AS POSSIBLE***

Present illness: *what is your chief complaint?*	
When did this condition begin?	
How severe is this condition?	(Mild) 1 2 3 4 5 6 7 8 9 10 (Severe)
Has it gotten better or worse since it began?	
What makes it better? What makes it worse?	
What treatment have you received already?	
What surgeries have you had? When did you have them?	
What other serious injuries or illnesses have you had?	
Date of last physical exam:	
Date of last laboratory work-up:	

Family History: Which, if any, of your blood relatives have had any of the following?

Condition	**Relationship**	**Condition**	**Relationship**
Stroke		Tuberculosis	
Cancer		COPD	
Heart Disease		Diabetes	
Obesity		Thyroid disease	
High Blood Pressure		Bleeding Disorders	

Medications & Allergies

Do you have any allergies that you know of?_____

Please list any medications, hormones, herbs or supplements that you are currently taking?

Medications	**Hormones**	**Herbs**	**Supplements**

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SLEEP

___ Do you suffer from insomnia?
___ Do you have trouble falling asleep or staying asleep?
___ Do you have restless sleep?
___ Do you have vivid or uncomfortable dreams?

DRUG HISTORY. Please indicate current or previous use of the following:

Now	Past	Years usage
____	____ Anti-depressants, mood modifiers	_____
____	____ Antibiotics	_____
____	____ Antacids (Prilosec, Tagamet, etc.)	_____
____	____ Asthma medications	_____
____	____ Birth control pills	_____
____	____ Hormone Replacement Therapy	_____
____	____ Steroids (Prednisone, etc.)	_____
____	____ Thyroid medication	_____

Do you smoke? Yes/No. If yes, how many cigarettes per day? _____

Alcohol intake per week: _____

EMOTIONS

Do you experience excessive:
___ Anger ___ Worry ___ Depression
____Fear ___ Sadness ___ Anxiety

How would you rate your current level of health?
(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How would you rate your current level of energy?
(Very poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

Name the three healthiest things you eat/ worst foods during the week:

1.	1.
2.	2.
3.	3.

To be filled out by practitioner:

BP	O2	BPM	Temp Core	Temp Extremities

Pulse Left:
Pulse Right:
Tongue:
Tongue Coat:

WOMEN ONLY

Do you have a history of:

___ Amenorrhea (long time spans without a period)
___ Breast implants. Were they removed? ____
___ Chronic vaginal or yeast infections
___ Endometriosis
___ Hysterectomy. What year? ____
___ Infertility
___ Irregular periods
___ Menstrual cramps
___ Miscarriage
___ Ovarian cyst (single)
___ Polycystic ovaries
___ Pelvic Inflammatory Disease (PID)
___ Uterine fibroids

Menstrual history.

____ Age of first period?
____ Are you presently pregnant?
____ Are you presently suffering from menopausal disorder?
____ Have you completed menopause?

Peri-menopause and Menopause

___ Do you experience hot flashes?
___ Do you have night sweats?
___ Do you feel your memory has declined recently?
___ Have you gained weight?

If you are still having your periods:

____ Length of cycle (days)?
____Date of your last period?
___ Is your period regular?
___ How many days between your periods?
___ How many days does your period last?
___ Are your periods painful?
___ Is your ovulation painful?
___ Do you bleed excessively? ____Too little?
___ Do you discharge clots?
___ Do you get headaches during menstruation or ovulation?
___ Do you suffer from premenstrual syndrome **(PMS)?**

If yes, please indicate:

___ Irritability ___ Breast distention
___ Headache ___ Water retention

How many days before your period do the PMS symptoms begin? ____

Pregnancy history.

How many times have you been pregnant? ____
Did you have difficulty getting pregnant? ____
Have you had any abortions? How many? ____
Have you had any miscarriages? How many? ____
Have you had an ectopic pregnancy? ____
Did you have difficulty following childbirth? ____

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NEW PATIENT INTAKE PACKET

CHECK ANY CURRENT CONDITIONS OR THOSE THAT YOU HAVE HAD IN THE PAST
(Please write the word **"PAST"** next to those conditions which you have ONLY had in the past and which are no longer present.)

HEAD & NECK:
_____ Dizziness
_____ Fainting
_____ Neck Stiffness
_____ Enlarged Lymph Glands
_____ Headaches
_____ Other

RESPITORY:
_____Chronic Cough
_____ Coughing Up Blood
_____ Coughing Up Phlegm
_____ Difficulty Breathing
_____ Wheezing/Asthma
_____ Frequent Colds
_____ Emphysema
_____ Pneumonia repeatedly
_____ Other

MALE:
_____ Pain/Itching of Genitalia
_____ Genital Lesions/Discharge
_____ Impotence
_____ Premature Ejaculation
_____ Prostate Problems
_____ Infertility
_____ Other

EARS:
_____ Infection
_____ Ringing
_____ Decreased Hearing
_____ Other

CARDIOVASCULAR:
_____ Palpitations
_____ Rapid Heart Rate
_____ Irregular Heart Rate
_____ Poor circulation
_____ Heart Disease
_____High blood pressure
_____Swollen ankles
_____ Phlebitis
_____Cold hands/feet
_____Stroke
_____Other

NOSE, THROAT, & MOUTH:
_____ Bleeding
_____Sinus Infection
_____ Hay Fever or Allergies
_____ Sore Throat
_____ Hoarseness
_____ Changes in Taste
_____ Difficulty Swallowing
_____Changes in Smell
_____ Oral Ulcers/Canker Sores
_____ Other

GASTROINTESTINAL
_____ Indigestion
_____ Nausea
_____ Stomach Pain
_____ Irritable Bowel Disease
_____ Colitis Habits
_____ Crohn's Disease
_____ Pancreatitis
_____ Celiac Disease
_____ Recent Change in Bowel Habits
_____ Diarrhea (_____ stools/day)
_____ Constipation (_____stools/day)
_____ Dry, Hard Stools
_____ Soft, Difficult, Sticky Stools
_____ Hemorrhoids
_____ Peptic Ulcer
_____ Blood in Stool or Black Stools
_____ Irregularity/Poorly formed stools
_____ Gall Bladder Disorder

URINARY:
_____ Frequent urinary tract/
_____ Bladder Infection
_____ Weak Urinary Stream
_____ Recent Change in Bladder
_____ Kidney Disease
_____ Frequent Night Urination
_____ Frequent Day Urination

SKIN:
_____ Hives
_____ Rashes
_____ Eczema
_____ Psoriasis
_____ Seborrhea
_____ Night Sweating
_____ Excess Sweating
_____ Dryness
_____ Bruises Easily
_____ Changes in Moles or Lumps
_____ Other

GENERAL:
_____ Fatigue
_____ Thirst
_____ Aversion To Cold
_____ Insomnia
_____ Excessive Hunger
_____ Poor Appetite
_____ Depression
_____ Frequent Dreams/Nightmares
_____ Agitation
_____ Irritability
_____ Recent Change in Weight
_____ Food Cravings
_____ Anemia

NEUROLOGICAL:
_____ Numbness or Tingling of Limbs
_____ Seizures
_____ Tremors
_____ Pain
_____ Paralysis
_____ Poor Memory
_____ Epilepsy or Convulsions
_____ Vomiting Blood
_____ Difficulty Concentrating
_____ History of Psychiatric Treatment
_____Other

MUSCLE & JOINTS
_____ Joint Disorder
_____ Sore Muscles
_____ Weak Muscles
_____ Difficulty Walking
_____ Backache
_____ Back Pain
_____ Surgical Implants
_____ Congenital Abnormalities
_____ Spinal Curvature
_____ Hernia
_____ Rheumatic Fever

NFECTION
_____ HIV/AIDS: Self / Partner
_____ TB: Self or Partner:
_____ Hepatitis: Self or Partner
_____ Hx of Sexually Transmitted Diseases
_____ Gonorrhea: Self or Partner
_____ Chlamydia: Self or Partner
_____ Syphilis Self or Partner
_____ Genital Warts Self or Partner
_____ Herpes: Oral or Genital (Circle 1 or Both)

SCREENING
_____ Fibromyalgia
_____ Cancer
_____ Thyroid Disorder
_____ Diabetes Mellitus_
_____ Epstein Barr Virus (EBV)
_____Lupus Erythematosis