Eden's Holistic Connection

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Dear Patient:

Thank you for your visit today. In order to provide you with holistic care and address the root cause of your health concerns, we would like you to complete a detailed and comprehensive health questionnaire. Your answers will help you achieve better treatment results. The more you are willing to share with us, the better we can treat the root cause of your health conditions and symptoms.

Patient's Name: _____ Date: _____

Doctor's Name _____ Referred By _____ Date _____

New Patient Intake Form

PATIENT DEMOGRAPHIC

Name: _____Gender: [ ]M, [ ]F

Date of Birth: _____ Age: _____ Height: _____ Weight: _____

Address : _____ City _____ State _____ ZIP _____

Cellphone: _____ Home Phone: _____ Work Phone : _____

Email : _____

Emergency contact: _____ Phone number: _____

What health problems would you like us to address on your initial visit? Please rank by priority:

1. _____
2. _____
3. _____

Prioritize your most important health concerns today?

Concern	**Onset**	**Frequency**	**Severity**
Ex: Headache	June 1978	4 times/wk	Mild/Mod/Severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____
6. _____	_____	_____	_____
7. _____	_____	_____	_____

What prior experiences have you had with alternative or complementary medicine?

_____

_____

_____

_____

With whom do you live? (Include roommates, friends, partner, spouse, children, parents, relatives, and pets)

Name	Age	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What are the major stressors in your life?

_____

_____

_____

What do you do to relax/relieve stress? What interests/hobbies do you have?

_____

Occupation (Current) : _____

(Past) : _____

_____

Spiritual beliefs/religious affiliations, past, and present:

_____

Source of comfort and connection: _____

HEALTH HABITS

What physical activity do you participate in, and how often?

_____

_____

_____

Energy level (1 lowest and 10 Highest): _____

Describe your sleep pattern

_____

_____

Nutrition

How many meals do you generally eat per day? _____ Do you skip Meals? _____

How many servings of fruit per day? (Svg: 1 small fruit, 1⁄2 C canned/chopped fruit, 1⁄4 C dried fruit)

_____

How many servings of vegetables do you consume each day? (Svg: 1⁄2 C raw/cooked, 1 C leafy veg.)

_____

Are you currently on a special diet? Food allergies? Foods you avoid? Vegetarian?

_____

_____

What are your sources of protein?_____

What type of oil or spreads do you add to your food?

_____

What and how much do you drink on a typical day? (i.e.: water, caffeine drinks, soda, etc.)

_____

_____

How would you describe your relationship with food?

_____

How often do you eat out? _____ who prepares the meals at home? _____

Tobacco

	Amount Per Day	Amount Per Week	Years of Used	Never Used
Cigarettes	_____	_____	_____	_____
Cigars/pipe	_____	_____	_____	_____
Chewing	_____	_____	_____	_____

Recreational Drugs

_____ _____ _____ _____

Alcohol

_____ _____ _____ _____

Have you ever had to cut down on your drinking? ___ Yes ___ No
Do you get annoyed when someone asks about your drinking? ___ Yes ___ No
Do you ever feel guilty about your drinking? ___ Yes ___ No
Do you ever make excuses for drinking or for your behavior while drinking? ___ Yes ___ No

PERSONAL MEDICAL HISTORY

Please check the following conditions that apply to you and circle the appropriate choice when given.

____ Alcoholism or Substance Abuse
____ Anemia (Sickle Cell or Other)
____ Arthritis/Joint Disease
____ Blood Clots/Phlebitis
____ Cancer (Specify Type: _____)
____ Digestive (Ulcerative Colitis, Crohns, etc.)
____ Diabetes
____ Easy Bleeding
____ Frequent Sinusitis
____ Gall Bladder Trouble
____ Hay Fever, Allergy, Eczema
____ Heart Attack, Heart Disease, Heart Failure
____ Heart Murmur
____ Headaches (Migraines, etc.)
____ High Blood Pressure
____ High Cholesterol
____ History of Infertility
____ Kidney Infection/ Stones
____ Liver Disease, Hepatitis, etc.
____ Lung Disease (Asthma, COPD, etc.)
____ Mental Trouble/ Depression/Anxiety, etc.
____ Pneumonia
____ Radiation Treatments
____ Rheumatic Fever
____ Seizures, Epilepsy
____ Serious Injury or Accident (Type _____)
____ Sexually Transmitted Disease (Chlamydia, Warts, Herpes, Specify Other_____)
____ Skin Disease
____ Tuberculosis (TB)
____ Stroke
____ Thyroid Disease
____ Vision Problems
____ Urinary Difficulties (Incontinence, Infections, etc.)
____ Root Canal / Mercury Filling (Amalgam), Specify_____
____ Fungal or MOLD exposure (Specify) _____
____ Other (Specify) _____

Please list any operations/surgical procedures/blood transfusion/major injuries (Dates):

_____
_____
_____
_____
_____

Immunizations/vaccinations:

_____
_____
_____

WOMEN ONLY

Reproductive History

Age at 1st menstrual period _____ First day of most recent menstrual period _____
Usual Flow: _____ Heavy _____ Moderate _____ Light Length of period in days _____
Number of days between periods _____
Do you have (please circle):
Painful Periods, Missed Periods, Spotting Between Periods, Vaginal Bleeding,
Unusual Discharge/Infection, Recurring Vaginal Infections
If you have gone through menopause, have you had any post-menopausal bleeding? _____
Date of last Pap _____ History of abnormal Paps?_____
Number of: Pregnancies_____ Live Births_____ Abortions _____ Miscarriages _____
Have you experienced complications during pregnancy/delivery/other problems?

_____
_____

Contraceptive History

Please circle the method of contraception you are currently using:
Birth Control Pills: Type _____ Total Years of Use _____
Diaphragm/Cap: Type _____ Size_____
IUD: Type _____ Date of Last Change _____
Norplant Condom and/or Foam Suppository Tubal Ligation
Hysterectomy Partner with Vasectomy None
Other_____
Problems with current method_____
Sexual Preference: _____Heterosexual _____ Homosexual ____Bisexual

MEN ONLY

Do you have: ____ Prostate Problems ____ Vasectomy
____ Testicular Cancer ____ Sexual Dysfunction
Sexual Preference: ____ Heterosexual ____ Homosexual ____ Bisexual

MEDICATIONS

What medications are you taking now? (Include prescription and over-the-counter drugs.)

Medication	Dosage Per Day	Reason	When Started
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Are you allergic to or have you had a "bad reaction" to any medications or other substances?

____ No ____ Yes

If yes, please specify drug(s) and type of reaction:

_____
_____
_____

What vitamins/mineral/herbal supplements are you taking now?

Brand/Other name(manufacturer)	Dosage Per Day	Reason	When Started
E.g.: St.John's Wort (Nature's Way)	300 mg/day	Feeling down	2 months ago
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			
_____			

FAMILY MEDICAL HISTORY

Who in your immediate family has any of the following?

Place appropriate letter in blank. (F=Father, M=Mother, S=Sibling, G=Grandparent)

_____ Alcoholism or Substance Abuse
_____ Anemia (Sickle Cell or Other
_____ Arthritis
_____ Cancer (Specify Type _____
_____ Diabetes
_____ Digestive (Ulcerative Colitis, Crohns, etc.)
_____ Easy Bleeding
_____ Glaucoma
_____ High Blood Pressure
_____ Hay Fever, Allergy, Eczema

_____ Headaches (Migraine, etc
_____ High Cholesterol
_____ Liver Disease (Hepatitis, etc.)
_____ Mental Trouble/ Depression/ Anxiety
_____ Seizure, Epilepsy
_____ Suicide
_____ Tuberculosis (TB)
_____ Other (Please Specify:_____)
_____ Heart Attack, Heart Disease, Heart Failure
_____ Kidney Disease
_____ Lung Disease (Asthma, COPD, etc.)
_____ Stroke
_____ Thyroid Disease
_____ Ulcers

DIAGNOSTIC STUDIES

Please indicate if you have had any of the following diagnostic studies, providing dates and test results as applicable.

Diagnostic	Date	Results/Comments
Genetic Testing		
MicroNutrient Panel		
Vitamin D		
Vitamin B12		
Heavy Metals		
Organic Acids		
Food Sensitivities		
Neurotransmitter		
Cardio Panel		
Thyroid		
Sex Hormones		

I authorize the health care provider to examine and treat my condition as deemed appropriate through the use of intravenous and/or intramuscular injection, acupuncture, Traditional Chinese Medicine, physical medicine and/or other natural healing methods.

Patient's / Guardian's Signature: _____ Date: _____

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Review of System (ROS)

(Please complete the form by circling the area you have current concerns about)

Today's Date : _____

Patient Name : _____ DOB : _____

General	Fatigue Fever Night sweat Recent weight loss Recent weight gain Significant appetite change	**Neurology**	Blackouts Tremors Carpal tunnel Weakness Fainting Numbness Paralysis Seizures
Skin	Abnormal mole Itching Color change Lumps Dryness Psoriasis Eczema Rashes Rosacea Hair or nail change Wart Skin Cancer	**Musculoskeletal**	Arthritis Muscle cramps Backache Neck pain Joint pain Past injury Joint swelling Joint stiffness
Head	Dandruff Hair loss Dizziness Headaches Dry hair Oily hair Migraines Light headedness Head injuries	**Urinary Tract**	Blood in urine Kidney stones Frequent urination Urgency Frequent infections Incontinence Pain in urination Waking to urinate
Eyes	Cataracts Itching Contact/glasses Glaucoma Dryness Styes Eye strain Watery Redness Dark circles around eyes Problems with vision Date of last exam: _____	**Gastrointestinal**	Abdominal pain Heartburn Constipation Hemorrhoids Diarrhea Liver Disease Food Intolerance Nausea Gas/ bloating Ulcers Indigestion **Rectal**: bleeding/ burning/ itching
Ears	Discharged Change in hearing Pain Recurrent infections Ringing Vertigo	**Respiratory**	Asthma Emphysema Bronchitis Pneumonia Cough Pain w/ breathing Shortness of breath w/ exertion Shortness of breath w/ sitting Shortness of breath w/ lying down Date of last Chest X-ray (if any): _____

Nose	Allergies Frequent colds Polyps Problem smelling Nose bleeds Sinusitis Nasal congestion Nasal discharge Postnasal discharge	**Cardiovascular**	Angina Arrhythmias Blue hands/ feet Edema Chest pain Heart attack Rheumatic Fever Murmurs Leg cramps Palpitations Varicose Vein TIA/ Stroke Low Blood Pressure High Blood Pressure Congestive heart failure Date of last ECG (if any): _____
Mouth/ Throat Neck	Cavities Dentures Gum Disease Sores Diminished Neck Goiter Hoarseness Movements Swollen glands Sore throat Problems tasting Problems swallowing	**Endocrine**	Anemia Diabetes Hormone Therapy Thyroid Irritability Mood Swings Easy bruising/ bleeding Increased thirst Increased urination Hot/cold intolerance Needing to eat regularly Snacking often
Mental/ Emotional/ Spiritual	Anxiety Anger/ irritability Fear/ panic Feeling down/ depressed Eating disorder Psychiatric hospitalization Suicidal thoughts Would you like prayer and anointing? Y/ N		