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www.Inspire4Health.com

New Patient Intake Form:

Name: _____ Age _____ Blood Type _____

Date of Birth: _____

Address: _____ City _____

State _____ Zip _____

Home Phone: _____ Business Phone _____

Cell Phone: _____ Email: _____

Occupation _____ Hours per week _____

Employer _____

Diet: Non-Vegetarian _____ Vegetarian _____ Vegan _____

Married _____ Separated _____ Divorced _____ Widowed _____

Single _____ Domestic Partner _____

Lives With: _____

Emergency Contact: Name _____ Phone _____

Address _____ City _____ State _____ Zip _____

How did you hear about us? _____

Pharmacy _____ Phone _____

Social Security # _____

Credit Card # _____ Security Code(3 digits) _____

Credit Card Billing address _____ Zip _____ Exp date _____

Patient's or Authorized Person's Signature

I authorize the release of any medical information necessary to process my insurance claims.

Signature _____ Date _____

Financial Responsibility

I understand that I am ultimately responsible for payment. *I also understand that I WILL be charged a fee for appointments that are not cancelled within 24 hours.* I further understand that I WILL be charged a maximum fee of \$20 for each returned check.

Signature _____ Date _____

Current Health Concerns: State your main reason for your visit today: _____

The general state of your health is: Excellent _____ Good _____ Average _____ Fair _____ Poor _____

Allergies: Are you allergic to medicines, herbs, foods, animals, environmental, or other substances? _____

Check if you have had or have any of the following medical conditions:

- | | | |
|--|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Fibromyalgia | <input type="checkbox"/> Multiple Sclerosis |
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Gonorrhea | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Seizures |
| <input type="checkbox"/> Autoimmune | <input type="checkbox"/> Herpes | <input type="checkbox"/> Sinusitis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High BP | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Chronic fatigue | <input type="checkbox"/> HIV | <input type="checkbox"/> Syphilis |
| <input type="checkbox"/> Chronic infections | <input type="checkbox"/> HPV | <input type="checkbox"/> Tonsillitis/Strep |
| <input type="checkbox"/> Depression/anxiety | <input type="checkbox"/> IBS | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Joint Prob | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Ear infections | <input type="checkbox"/> Lung Dis | <input type="checkbox"/> Suicide Attempt/Thoughts |
| <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Migraines | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Digestive Problems |
| <input type="checkbox"/> Hives/Rashes | <input type="checkbox"/> Bladder Prob | <input type="checkbox"/> Alcoholism |
| <input type="checkbox"/> Addictions | <input type="checkbox"/> High Chol | <input type="checkbox"/> Liver Disease |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Sleep Apnea | <input type="checkbox"/> Kidney Problems |
| <input type="checkbox"/> Prostate Infections | | |

Any Surgeries? _____

Any Accidents? _____

Any X-rays, CT, MRI's _____

Any trauma, shock, grief, major disappointments, or fright? _____

Vaccinations: MMR _____ HepB _____ Tetanus _____ Meningitis _____

BCG _____ Small Pox _____ Typhoid _____ Flu _____

Have you traveled outside the U.S.? If so when and where _____

Do you have any silver amalgam fillings? _____

Family History: any illnesses or chronic diseases?

Mother _____

Father _____

Maternal grandfather _____ Maternal grandmother _____

Paternal grandfather _____ Paternal grandmother _____

Siblings _____

Diet: Typical Breakfast _____

Lunch: _____

Dinner: _____

Snacks and how often: _____

How many servings of red meat per week? _____ Dairy _____

How many glasses on an average day? Coffee _____ Green Tea _____ Water _____

Fruit juice _____ Milk _____ Soda _____ Diet soda _____ Beer _____

Wine _____ Liquor _____

What is the source of your drinking water? Tap _____ Bottled _____ Filtered _____

Distilled _____

Tobacco: No _____ Yes _____ if yes, Cigs _____ Cigars _____ Chewing Tobacco _____

How often? _____

Any drug usage? _____ Any IV drug use? _____

Ever had problems with addiction? Food _____ Alcohol _____ Drugs _____

How many hrs of sleep? _____ Do you feel refreshed? _____ Do you wake up at night?

_____ How often? _____

Do you regularly use? Laxatives _____ Diuretics _____ Sleeping pills _____

Antacids _____ Pain killers _____ If so, how often?

Do you exercise? _____ If so how often and what type? _____

When was your last vacation? _____

What is your level of stress? Minimal _____ Average _____ Considerable _____

Unbearable _____

What is your main stressor? Financial _____ Job related _____ Health _____

Marriage _____ Interpersonal _____

Do you currently work with a professional counselor , social worker, psychologist, religious counselor, or other kind of therapist? Yes _____ No _____

Vitamins/Supplements:What and how often? _____

Medications: What do you take, for how long, and how often? _____

Any recent antibiotics? _____

Do you use probiotics? _____

Any exposure to toxic substances? Heavy Metals _____ Mold _____ Chemicals _____
Fumes _____

Women's Health:

Age of first menses? _____ Painful periods? _____ Are they regular? _____

Age of cessation of menses? _____ Any difficulties? _____

Do you experience PMS? _____ If so, what are your symptoms? _____

Do you use birth control? _____ What type? _____

Have you ever had a sexually transmitted disease? _____

Ever been HIV tested? _____ If so when? _____

How many pregnancies? _____ Abortions? _____ Miscarriages? _____

Stillbirths? _____

Have you ever had an abnormal pap smear? If so when? _____

Do you perform regular breast exams? _____ How often? _____

Is there a family history of breast cancer? _____

Do you have recurring yeast infections? Never _____ Rarely _____ Frequently _____

Do you have recurring bacterial vaginosis? Never _____ Rarely _____ Frequently _____

Do you have recurring bladder infections? Never _____ Rarely _____ Frequently _____