



**ecohealth & wellness**  
inspiration for healthy living

## New Patient Intake Form

Patient Name: \_\_\_\_\_ Date: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Current Age: \_\_\_\_\_

Street Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Home phone: \_\_\_\_\_ Work Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_

Highest level of education: \_\_\_\_\_

Occupation: \_\_\_\_\_ Employer \_\_\_\_\_ Hours work per week: \_\_\_\_\_

Marital Status (circle): Single Married Separated Divorced With Partner Widow(er)

Person to call in case of Emergency: \_\_\_\_\_

Relationship to you: \_\_\_\_\_

Phone number contact for them: \_\_\_\_\_

Regular Physician: \_\_\_\_\_

How did you hear about Tiffany: \_\_\_\_\_

List in Order of Importance what your problems are:

1.

2.

3.

4.

5.

Last time you had blood work done and with what doctor: \_\_\_\_\_



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## Family history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

## List All Surgeries and Hospitalizations—including date occurred:

- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_
- \_\_\_\_\_

## Please Note When and Why You Had Each of The Following:

X-rays: \_\_\_\_\_  
 MRI/Cat Scans: \_\_\_\_\_  
 Ultrasounds: \_\_\_\_\_  
 Accidents: \_\_\_\_\_

## List All Sensitivities/Allergies/Reactions

Drugs: \_\_\_\_\_  
 Foods: \_\_\_\_\_  
 Environment: \_\_\_\_\_

## Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D   I   N	Diphtheria:	D   I   N
Mumps:	D   I   N	Tetanus:	D   I   N
Rubella:	D   I   N	Whooping Cough:	D   I   N
Chickenpox:	D   I   N	Hemophilus (Hib):	D   I   N
German Measles:	D   I   N	Hepatitis B:	D   I   N

Any vaccination reactions: \_\_\_\_\_



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### List Yes, No, or Past regarding use of the following:

Antacids:	Y N P	Steroids:	Y N P
Smoking:	Y N P	Packs per day if Yes/Past:	_____
Analgesics:	Y N P	Laxatives:	Y N P
Coffee:	Y N P	Cups per day if Yes/Past:	_____
Soda Pop:	Y N P	Ounces per day if Yes/Past:	_____
Alcohol:	Y N P	How often and how much if Yes/Past:	_____
Any alcohol addiction:	Y N P		
Any alcohol treatment:	Y N P		
Recreational drugs:	Y N P		
Any drugs addiction:	Y N P		
Any drug treatment:	Y N P		

### List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

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### Review Of Systems:

Present Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_  
 Height: \_\_\_\_\_ Maximum weight and when: \_\_\_\_\_  
 Minimum Weight as adult and when: \_\_\_\_\_  
 Ideal Weight: \_\_\_\_\_

**REGARDING THE NEXT SECTION: Please Circle Y (for YES) if you have the problem NOW, N if you've NEVER had the problem, P if you had the problem in the PAST.**

Fatigue: Y N P  
 If you have fatigue, when in morning, afternoon, evening is it the worst?: \_\_\_\_\_  
 If you have fatigue, can you do what you need to during the day?: Y N

#### Skin:

Rash:	Y N P	Color Change:	Y N P
Hives:	Y N P	Lump:	Y N P
Psoriasis/eczema:	Y N P	Itchy:	Y N P
Dry:	Y N P	Warts/moles:	Y N P
Cancer:	Y N P	Perspiration:	Y N P



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## **Head:**

Headache: Y N P  
Dandruff: Y N P  
Oil/dry hair: Y N P

Migraine: Y N P  
Head Injury: Y N P  
Hair loss: Y N P

## **Eyes:**

Dry/Watery: Y N P  
Double vision: Y N P  
Glaucoma: Y N P  
Strain: Y N P  
Itchy: Y N P

Blurry vision: Y N P  
Cataracts: Y N P  
Styes: Y N P  
Discharge: Y N P  
Dark under eyelid: Y N P

## **Nose:**

Frequent colds: Y N P  
Congestion: Y N P  
Polyps: Y N P

Nosebleeds: Y N P  
Post nasal drip: Y N P  
Seasonal allergies: Y N P

## **Mouth/Throat:**

Canker sores: Y N P  
Sore throat: Y N P  
Dentures: Y N P  
Loss of taste: Y N P

Cold sores: Y N P  
Gum disease: Y N P  
Cavities: Y N P  
Hoarseness: Y N P

## **Neck:**

Stiffness: Y N P  
Full movement: Y N P

Swollen glands: Y N P  
Tension: Y N P

## **Respiratory:**

Cough: Y N P  
Shortness of breath with exertion: Y N P  
Shortness of breath sitting: Y N P  
Shortness of breath lying down: Y N P  
Wheezing: Y N P

TB: Y N P  
Bronchitis: Y N P  
Pneumonia: Y N P  
Asthma: Y N P  
Painful breathing: Y N P

## **Cardiovascular:**

High blood pressure: Y N P  
Low blood pressure: Y N P  
Arrhythmias: Y N P  
Edema: Y N P

Rheumatic Fever: Y N P  
Murmurs: Y N P  
Palpitations: Y N P  
Chest pain: Y N P



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## **Gastrointestinal:**

Heartburn: Y N P  
Indigestion: Y N P  
Bloating: Y N P  
Nausea : Y N P  
Vomiting: Y N P  
Change in Appetite: Y N P  
Pancreatitis: Y N P

Bowel movement frequency: \_\_\_\_\_  
Recent change in BM: Y N P  
Diarrhea or constipation: Y N P  
Hemorrhoids: Y N P  
Gall bladder disease: Y N P  
Liver disease: Y N P  
Ulcer: Y N P

## **Urinary Tract:**

Incontinence: Y N P  
Frequent infections: Y N P  
Urgency: Y N P

Pain with urination: Y N P  
Kidney stones: Y N P  
Discharge/blood: Y N P

## **Male:**

Testicular pain/swelling: Y N P  
Hernia: Y N P  
Discharge: Y N P  
Impotency: Y N P

Sexually active: Y N P  
Sexually transmitted disease: Y N P  
Prostate disease/symptoms: Y N P  
Sexual orientation: Hetero Homo Bi

## **Female:**

Age periods began: \_\_\_\_\_  
How long periods last: \_\_\_\_\_  
Periods:  
Heavy Bleeding: Y N P  
Cramping: Y N P  
Pain: Y N P  
PMS: Y N P  
Food Cravings: Y N P  
Last Pap Smear: \_\_\_\_\_  
Diagnosis: \_\_\_\_\_  
Any abnormal paps: Y N P  
When was abnormal: Y N P  
Any Birth Control (please list types and ages used): \_\_\_\_\_  
Sexually Transmitted Diseases: Y N P  
Mammography: Y N P  
Dexa Scan: Y N P If Yes, what were the results: \_\_\_\_\_  
Use of Hormones: Y N P

How often periods occur: \_\_\_\_\_  
Menopausal since what age: \_\_\_\_\_  
Times Pregnant: \_\_\_\_\_  
How many births: \_\_\_\_\_  
Miscarriages: \_\_\_\_\_  
Abortions: \_\_\_\_\_  
Sexual Active: Y N P  
Healthy Libido: Y N P  
Pain With Intercourse: Y N P  
Dry Vagina: Y N P  
Vaginitis: Y N P



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### **Musculoskeletal:**

Weakness: Y N P  
Stiffness: Y N P  
Tremors: Y N P

Arthritis: Y N P  
Leg cramps: Y N P  
Pain: Y N P

### **Nervous:**

Paralysis: Y N P  
Tingling/numbness: Y N P  
Seizures: Y N P

Sciatica: Y N P  
Carpal tunnel syndrome: Y N P  
Fainting: Y N P

### **Mental/Emotional:**

Depression: Y N P  
Suicidal: Y N P  
Anxiety: Y N P

Anger/irritability: Y N P  
High-strung/tense: Y N P  
Fear/Panic: Y N P

### **Exercise:**

How often: \_\_\_\_\_  
What type(s): \_\_\_\_\_  
For How long: \_\_\_\_\_

### **Hobbies:**

\_\_\_\_\_  
\_\_\_\_\_

### **Sleep:**

How long per night: \_\_\_\_\_  
If you wake up frequently, what is the reason: \_\_\_\_\_  
Nightmares: Y N P  
Wake refreshed: Y N P  
Must Nap during the day: Y N P  
Sleep walk: Y N P  
Grind Teeth: Y N P  
Snore: Y N P

### **Food:**

Appetite Good?: Y N P  
Foods crave: \_\_\_\_\_  
Foods Dislike: \_\_\_\_\_  
Foods that don't sit well: \_\_\_\_\_



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## **Toxin Exposure:**

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: \_\_\_\_\_

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?: \_\_\_\_\_

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?: \_\_\_\_\_

Are you particularly sensitive to perfumes, gasoline, or other vapors?: \_\_\_\_\_

Do you use pesticides, herbicides, other chemicals around your home? \_\_\_\_\_

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## **Social Life:**

Enjoy job?: Y N P

Active Spiritual practice: Y N P

Quality of most significant relationship? \_\_\_\_\_

History of sexual, mental/emotional, physical abuse?: Y N

If so, at what age and by whom?: \_\_\_\_\_

What is your greatest health concern? \_\_\_\_\_

How does it limit you the most? \_\_\_\_\_

How committed are you towards making valuable changes: Little Moderately Very

**Please use the rest of the page to write any additional you comments you may have about the reason for your visit.**