



New Patient Intake Form

Welcome to THE POINT. We are committed to providing you the best medical care possible.
Please help me provide you with a complete evaluation by taking the time to fill out this questionnaire carefully.

Name _____ Date _____
 Age _____ Date of Birth _____ Occupation _____
 Address _____ Home phone _____
 City State Zip _____ Cell phone _____
 Email _____ Work phone _____
 How did you hear about us? _____
 Friend Ad Website Doctor Other _____
 Your preferred phone # Home Work Cell
 May we leave a message? Y N

What are your primary reasons for coming in for treatment?

1 _____
 2 _____
 3 _____

When did you first notice this problem/How long have you experience it? _____

Your current Doctor(s): Name _____ Phone # _____
 Address _____
 Date of last physical exam _____ Date of last blood work _____ Diagnosis _____

Lab tests done in last two years (please attach any lab results you would like considered) _____

Emergency Contact _____ Relationship _____ Phone _____

Insurance Company: _____ Policy ID# _____
 Group # _____ Phone # _____ If you're insured through a parent or spouse,
 please provide their name and birthdate: _____

Have you been diagnosed with any of the following:

-
- | | |
|--|---|
| <input type="checkbox"/> Hypertension | <input type="checkbox"/> Autoimmune Disease |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Cancer |
| <input type="checkbox"/> Osteopenia/Osteoporosis | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Bleeding Disorder |
| <input type="checkbox"/> Anxiety | <input type="checkbox"/> Fibromyalgia |
| <input type="checkbox"/> Emotional Disorder | <input type="checkbox"/> High Cholesterol |
| <input type="checkbox"/> GERD/Reflux | <input type="checkbox"/> Heart Disease |
| <input type="checkbox"/> AIDS/HIV | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Infertility |
| <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> Chronic Fatigue Syndrome |

Please indicate if you have or are taking any of the following:

- Pacemaker
- Clotting Disorder
- Contagious Disease
- Sleeping Aids
- Blood Thinners (Warfarin, Coumadin, etc)
- Thyroid medication
- Cortisone or other Steroids
- Diet Pills (diuretics, appetite suppressants, etc.)
- Laxatives
- Antacids (Tums, etc.)
- Pain Relievers (Tylenol, Aspirin, etc.)
- Tranquilizers/Sedatives

Please list any hospitalizations and/or surgeries/injuries/accidents:

Hospitalization/Surgery/Accident/Injury	Date	Reason / Relation to health concerns

Please list all prescription and over-the-counter medications you are currently taking:

Name	Dosage	Reason for taking	Date began taking

Please list all vitamins, supplements, herbs, performance enhancing aids and/or weight loss products:

Name	Dosage	Reason for taking	Date began taking

Approximately how many courses of antibiotics have you taken in the past 10 years? _____

Allergies (drug, chemical, food, seasonal): _____

Family Health History (Parents and Siblings)

- Arthritis
- Drug Addiction
- Mental Illness
- Asthma
- Eating Disorder
- Migraine headaches
- Alcoholism
- Genetic Disorder
- Parkinson's
- Alzheimer's disease
- High Blood Pressure
- Obesity
- Cancer
- Heart Disease
- Osteoporosis
- Depression
- Infertility
- Stroke
- Diabetes
- Learning Disabilities
- Suicide

Survey of Symptoms: Please check current symptoms (** the ones that occur frequently, and write “past” next to those conditions which you have only had in the past and are no longer present).

Head & Neck:

- Dizziness
- Floaters
- Blurry vision
- Neck Stiffness
- Enlarged lymph glands
- Headaches
- Migraines
- TMJ

Ears:

- Infection
- Ringing
- Decreased hearing

Nose, Throat, & Mouth:

- Nose bleeds
- Nasal congestion
- Sinus infection
- Hay fever/ allergies
- Sore throat
- Hoarseness
- Mouth sores
- Dry mouth

Skin:

- Hives / Rashes
- Eczema
- Psoriasis
- Acne
- Night sweating
- Excess sweating
- Dry skin
- Bruise easily

Respiratory:

- Chronic cough
- Coughing up blood
- Coughing up phlegm
- Difficulty breathing
- Asthma/Wheezing
- Catch cold easily
- Emphysema
- Pneumonia

Gastrointestinal:

- Indigestion
- Nausea
- Vomit
- Bloating
- Gas
- Heartburn
- Distention of abdomen
- Stomach pain
- Irritable Bowel
- Colitis
- Crohn’s Disease
- Celiac Disease
- Ulcer
- Bad Breath
- Diarrhea
- Constipation
- Dry, hard stools
- Soft, sticky stools
- Blood in stools/black stools
- Hemorrhoids
- Poor appetite
- Excessive hunger
- Excessive thirst
- Gall Bladder problems/stones
- Recent weight change
- Food cravings
- Hypoglycemia

Urinary:

- Frequent day urination
- Frequent night urination
- UTI/bladder infection
- Weak urine stream/dribbling
- Kidney disease
- Recent change in bladder habits

Muscle & Joints:

- Arthritis
- Joint stiffness
- Sore muscles
- Weak muscles
- Back pain
- Sciatica
- Fibromyalgia

Cardiovascular:

- Palpitations
- Chest pain or tightness
- Rapid heart beat
- Irregular heart beat
- Heart disease
- Poor circulation
- Cold hands/feet
- Swelling ankles
- High blood pressure
- Stroke
- Anemia

Infection:

- HIV/AIDS
- TB
- Hepatitis
- STD
- Herpes

Neurological:

- Numbness or tingling
- Seizures / Convulsions
- Tremors
- Paralysis

General:

- Fatigue
- Thirst
- Chills/aversion to cold
- Insomnia
- Depression
- Agitation/Anxiety
- Irritability
- Poor memory
- Difficulty concentrating
- Jaundice
- Gout
- Hernia
- Diabetes Mellitus
- Thyroid disorder
- Cancer
- Alcoholism
- Lowered libido
- Other _____

Is there anything else you would like us to know? _____

Thank you for taking the time to answer these questions, we appreciate your time and effort.
I certify that the information I have provided above is correct and accurate to the best of my knowledge.

Patient's (or Patient Representative's) Signature *Patient's Name* *Date*

Patient Representative's Name *Representative's relationship to patient*