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? _____ Your preferred phone # Home Work Cell
□ Friend □ Ad □ Website □Doctor □ Other _____ 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:

- □ Hypertension
- □ Diabetes
- □ Osteopenia/Osteoporosis
- □ Depression
- □ Anxiety
- □ Emotional Disorder
- □ GERD/Reflux
- □ AIDS/HIV
- □ Arthritis
- □ Asthma
- □ Migraine headaches
- □ Autoimmune Disease
- □ Cancer
- □ Epilepsy
- □ Bleeding Disorder
- □ Fibromyalgia
- □ High Cholesterol
- □ Heart Disease
- □ Stroke
- □ Thyroid Disorder
- □ Infertility
- □ Chronic Fatigue Syndrome

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

□ Pacemaker
□ Sleeping Aids
□ Cortisone or other Steroids
□ Antacids (Tums, etc.)
□ Clotting Disorder
□ Blood Thinners (Warfarin, Coumadin, etc)
□ Diet Pills (diuretics, appetite suppressants, etc.)
□ Pain Relievers (Tylenol, Aspirin, etc.)
□ Contagious Disease
□ Thyroid medication
□ Laxatives
□ 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
□ Asthma
□ Alcoholism
□ Alzheimer's disease
□ Cancer
□ Depression
□ Diabetes
□ Drug Addiction
□ Eating Disorder
□ Genetic Disorder
□ High Blood Pressure
□ Heart Disease
□ Infertility
□ Learning Disabilities
□ Mental Illness
□ Migraine headaches
□ Parkinson's
□ Obesity
□ Osteoporosis
□ Stroke
□ 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 _____

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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*	

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