Origin Health Center

NEW PATIENT INTAKE FORM

Patient's Name:				☐M ☐F	Date of Birth:	
Marital Status:	☐ Married	☐Single	☐Divorced	☐Separated	☐Widowed	☐Partnered
Highest Education Level:						
Current Weight:		Maximum Weight:		Ideal Weight:		Height:

Please list your current health concerns in order of importance:
1
2
3
4
5

Did you have the following Disease (D), get Immunized (I) or Neither (N)		
Measles ☐D ☐I ☐N	Mumps ☐D ☐I ☐N	Rubella ☐D ☐I ☐N
Chicken pox ☐D ☐I ☐N	Tetanus ☐D ☐I ☐N	Whooping cough ☐D ☐I ☐N
HiB ☐D ☐I ☐N	Hep B ☐D ☐I ☐N	Polio ☐D ☐I ☐N
Pneumococcal ☐D ☐I ☐N	HPV ☐D ☐I ☐N	Any vaccine reactions?

Please list any medical problems diagnosed by other doctors:

Please list all surgeries and hospitalization:		
Date	Reasons:	Hospital:

Please list when and why you had the following:	
X-Ray:	
MRI/Cat Scans:	
Ultrasounds:	
Accidents:	
TB Tests:	
HIV:	

Origin Health Center

HCV:	
Last Eye Exam:	
Last Dental Visit:	

Please list the prescribed medication you are currently taken?		
Name:	Strength:	Frequency taken:

Please list the over the counter medications and supplements you are currently taken?		
Name:	Strength:	Frequency taken:

Please list any allergies to medication or foods:	
Name:	Reaction you had:

Please list Yes (Y), No (N), or Past (P) regarding the use of the following:
Smoking: ☐Y ☐N ☐P If yes, how many a day?
Coffee: ☐Y ☐N ☐P
Soda pop: ☐Y ☐N ☐P If yes, how many a day?
Alcohol: ☐Y ☐N ☐P If yes, how much a day?
Laxatives: ☐Y ☐N ☐P
Antacids: ☐Y ☐N ☐P

Origin Health Center

Any alcohol addiction: ☐Y ☐N ☐P Recreational drugs: ☐Y ☐N ☐P	Any alcohol treatment: ☐Y ☐N ☐P Any drug addiction: ☐Y ☐N ☐P
Any drug treatment: ☐Y ☐N ☐P	

FAMILY HISTORY:
Mother's age and significant health problems:
Father's age and significant health problems:
Siblings' ages and significant health problems:
Children's ages and significant health problems:

Do you have any blood relative who has any of the following:					
Autism ☐	Anemia ☐	Arthritis ☐	Asthma ☐	OCD ☐	Diabetes Mellitus ☐
TB ☐	Heart Disease ☐		Auto-immune Disease ☐		High Blood Pressure ☐
Seizures ☐	Sickle Cell Anemia ☐		Osteoporosis ☐		Mental Illness ☐
Stroke ☐	Cancer ☐	Hep C ☐	Other ☐		

WOMAN ONLY		
Age of menstruation:	Date of last menstruation:	
Length of period:	Quality of period: ☐Heavy ☐Irregular ☐Spotting ☐Pain	
Do you have any ☐tension, ☐pain, ☐bloating, ☐irritability or ☐ other symptoms around or during your period?		
Number of pregnancies:	Number of live births:	Are you breastfeeding? ☐Yes ☐ No
Have you had ☐D&C, ☐Hysterectomy, or ☐Cesarean?		
Have you had any ☐urinary tract, ☐bladder, or ☐kidney infections within the last year?		
Do you have any hot flashes or sweating at night? ☐Yes ☐No		
Do you have vaginal dryness? ☐Yes ☐No		
Do you have pain with intercourse? ☐Yes ☐No		
When did you start menopause?		
Have you experienced any recent ☐breast tenderness, ☐lumps or ☐nipple discharge?		
What is your sexual orientation? ☐Hetero ☐Homo ☐Bi		
Have you had any STD? ☐Yes ☐No		
Date of last pap smear:	Result:	
Date of last mammogram:	Result:	
Date of last Dexa Scan:	Result:	

MAN ONLY
What is your sexual orientation? ☐Hetero ☐Homo ☐Bi
Do you usually get up to urinate during the night? ☐Yes ☐No
Do you feel pain or burning during urination? ☐Yes ☐No

Origin Health Center

Do you have any blood in your urine? ☐Yes ☐No
Do you feel burning discharge from penis? ☐Yes ☐No
Has the force of your urination decreased? ☐Yes ☐No
Have you had any ☐urinary tract, ☐bladder, or ☐kidney infections within the last year?
Do you have nay problem emptying your bladder completely? ☐Yes ☐No
Do you have any difficulty with erection or ejaculation? ☐Yes ☐No
Do you have any testicle pain or swelling? ☐Yes ☐No
Do you have any hernia? ☐Yes ☐No
Have you had any STD? ☐Yes ☐No
Date of last prostate and rectal exam:

REVIEW OF SYSTEM	
Please circle symptoms you currently have or had in the last 12 months	
General:	chills, fever, weight loss, fatigue, cravings, weight gain, changes in appetite, trouble sleeping, cold hand and feet, night sweats, poor memory, other:
Cardiovascular:	chest pain, high blood pressure, low blood pressure, poor circulation, swelling of ankles, varicose veins, difficult breathing,rheumatic fever, murmurs, palpitation, arrythmias, other:
Skin:	bruise easily, eczema, psoriasis, hives, itching, changes in moles, ulcerations, change in hair/skin texture, hyperpigmentation, hypopigmentation, dandruff, oily/dry hair, cancer, other:
Musculoskeletal:	muscle weakness, muscle pain, back pain, neck pain, joint pain, sciatica, carpal tunnel syndrome, paralysis, numbness, arthritis, leg cramps, other:
EENT	dry/watery/itchy eyes, glaucoma, cataracts, sties, blurred vision, double vision, vision loss, night blindness, earache, ringing in ears, hay fever, hoarseness, congestions, polyps, nosebleed, sinus problems, difficulty swallowing, cold sores, canker sores, dentures, loss of taste, gum disease, cavities, other:
Gastrointestinal:	poor appetite, pancreatitis, heartburn, gallbladder disease, liver disease, ulcer, bloating, constipation, diarrhea, vomiting, gas, hemorrhoids, indigestion, nausea, rectal bleeding, stomach pain, bad breath, belching, black stools, other:
Neurological:	headache, dizziness, tremors, fainting, seizures, forgetfulness, nervousness, anxiety, numbness, other:
Endocrine:	excessive thirst, excessive hunger, hormonal imbalance, heat or cold intolerance, weight gain/loss, other:
Genito-urinary:	frequent urination, painful urination, poor bladder control, kidney stones, blood in urine, other:
Respiratory:	pneumonia, asthma, TB, persistent cough, wheezing, production of phlegm, shortness of breath, other:
Mental:	depression, suicidal, anxiety, eating disorder, anger, irritability, fear, panic, other:

Origin Health Center

SOCIAL HISTORY	
Energy on scale of 1 (worst) to 10 (best):	
How many hours do you sleep a night?	
What is the quality of your sleep?	
During sleep, do you: ☐Grind teeth ☐Perspire ☐Talk ☐Snore ☐ Walk ☐ Have nightmare	
Are you currently in a happy relationship? ☐Very ☐Mostly ☐ Somewhat ☐No	
Occupation:	Employer:
Hours work per week:	Do you enjoy your work? ☐Yes ☐No
Are you sexually active?If Yes, are you trying for a pregnancy? If No, list contraceptive method	
Are you exposed to any hazardous substances? If Yes, what kind? ☐Yes ☐No	
Do you do any kind of physical activities? How often and how much? ☐Yes ☐No	
Do you have a religion or spiritual practice? If Yes, what kind? ☐Yes ☐No	
Do you have a hobby? If Yes, what kind? ☐Yes ☐No	
Are you particularly sensitive to perfumes or any vapors? If Yes, what kind? ☐Yes ☐No	
Do you have any sexual/mental/physical abuse? If Yes, What age and by whom? ☐Yes ☐No	
What is your greatest health concern?	
How does it limit you the most?	
How committed are you towards making valuable changes? ☐Little ☐ Moderately ☐Very	