Peter Bongiorno ND, L Ac **Pina LoGiudice, ND, LAc**
www.InnerSourceHealth.com

PATIENT INTAKE FORM

Date:

Name:

Date of Birth:

Address:

Home phone:

Work phone:

Cell phone:

Email:

May we add your email to our newsletter? Yes ____ No _____
(your email will not be shared or used for any other purpose)

How did you hear about our practice:

"X" all that apply: Is it o.k. to leave a phone/mail message regarding your care at:

- [ ] home
- [ ] work
- [ ] cell phone
- [ ] email

Emergency Contact Information:
Name:
Relationship:
Phone Number:

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Please list your health concerns in order of priority along with other practitioners you may be seeing for the condition. Plr

condition	practitioner	Practitioner phone #	address
1)			
2)			
3)			
4)			
5)			

Is it okay to contact your practitioners about your case? If O.K, please sign below:

Signed: ____ date: ___________

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	Reason:	Date began:	Dose:	Helps? Yes or no

Supplements:	Reason:	Date began:	Dose:	Helps? Yes or no

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PLEASE CHECK AND DESCRIBE ANY PROBLEMS OR CHANGE IN FUNCTION IN THE PAST OR PRESENT IN ANY OF THESE AREAS (the notes in parentheses are examples. Please don't limit your responses to these

___ Headaches
___ Weight
___ Vision
___ Nose/sinuses (example: allergies, sinus infections)
___ Throat (example: recent or recurrent infections)
___ Digestive tract problems (example: bowel problems, hemorrhoids, hernias, diarrhea, bloating)

How often do you have a bowel movement?

___ Energy
___ Body temperature
___ Other eye problems (infections, sties)
___ Mouth/teeth/gums (including dental procedures)
___ Skin (eczema, infections, rashes)
___ Heart disease (rheumatic fever, shortness of breath, palpitations)
___ Stomach (ulcers, reflux, etc)
___ Musculoskeletal concerns (arthritis, joint problems, Osteoporosis, muscle pain, weakness):___
___ Other:__________

FOR WOMEN:

Are you currently experiencing any gynecological symptoms or problems?______
Are you currently sexually active?_____ Partner(s) is/are __Male __Female
If sexually active, do you perform safe sex practices?____________________________________
Any problems related to sexual function?____
History of sexually transmitted diseases?______________________ Genital worts?___________
Number of pregnancies?____ Births?____ Abortions?____ Miscarriages?____
Date of last Pap Smear?_____________ Abnormal Pap?__________________________________
How frequent do you have a gyn exam/ pap smears? ____________________________________
Any cervical cancer history? _____________if yes, when:_________________________
Any ovarian cancer history? _____________if yes, when:_________________________
Do you perform regular breast self exams? _____yes ____no
If menopausal or perimenopausal: List symptoms and concerns:_____________
____
Any personal history of breast cancer?____

FOR WOMEN WHO ARE OF MENSTRUATING AGE:

Onset of first menses was age___. Periods generally last ___ days and occur every ___ days.
Date of last period _____________ Bleeding is __Heavy __Moderate __Light
Do you experience PMS symptoms?_____ List:____

FOR MEN:

Are you currently sexually active?_____ Partner(s) is/are __Male __Female
History of sexually transmitted diseases?______________________ Genital worts?___________

Date of last prostate exam?____________
Trouble with urination? (frequency, hesitancy, pain, dribbling)___________________________
Trouble with sexual function/libido?__ __ If yes, explain:

PLEASE DESCRIBE YOUR FAMILY'S HEALTH: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

SURGERIES:

Age:	Description:

DIET: Please describe a typical day's diet for you

Breakfast	Lunch	Dinner	Snacks (what hour)

Sources and amounts of:
Caffeine:______________________
Alcohol:________________
Smoking history and amount:______________

WEIGHT and HEIGHT:

	Current	Past year	Past 5 years
Weight			
Height			

ALLERGIES: please list any life threatening or severe allergies to drugs or foods that you know of:
1.
2.
3.

LIFESTYLE:
What are your current primary sources of stress?
1.
2.
3.
How much do you think they impact you life?___________
Occupation? __________________________ Do you like your work? _______________
How many hours do you work per week?______ Number of play/relaxation hours?_______
What do you do in order to manage stress and take care of yourself? : _____________
What is your exercise routine?: ____
What is your favorite magazine and newspaper? ___
What is your favorite radio station? __

OTHER MEDICAL/SAFETY QUESTIONS:
Date of last full physical?___________ if abnormal, explain:___________
Date of last dermatology checkup?_______ if abnormal, explain:________
Any personal history of skin cancer? ____yes _____no
If over age 50, have you had a colonoscopy? ____yes _____no
Dates of colonoscopy? _______________________________
Any positive findings on colonoscopy? ___yes___no, if yes, explain:__________

Date of last visual acuity exam?______if abnormal, explain: ____________
Date of last ophthalmologic exam? _________ if abnormal, explain: _________
Do you use seat belts while riding in a car? ____yes _____no
Do you have a fire alarm in your home? ____yes _____no
Do you have a carbon monoxide (CO) detector in your home? ____yes _____no
Do you have a fire extinguisher in your home? ____yes _____no
Do you visit the dentist regularly? ___yes ____no If yes, how frequent? __
Do you have dental problems, gum inflammation, bleeding and/or gingivitis? Circle which and explain:

Please list your three greatest stressful life events and their date:
1)
2)
3)

Please list your three happiest life events and their date:
1)
2)
3)

What do you believe is your greatest challenge?

Thank you for your time and for filling this form out as completely as possible. Please remember all information given is strictly confidential. Please print a copy and bring to your first appointment.