303.377.1365
www.inspired-wellness.com

PATIENT INTAKE FORM

Please take the time to fill out this questionnaire carefully. The information you provide will assist us in formulating a complete health profile for you. All of your answers are absolutely confidential. If you have any questions, please ask.

Name: _____

Date : _____

Address: _____

City: _____ State _____ Zip : _____

Home Phone: _____

Work Phone: _____

Email : _____

Date of Birth (dd-mm-yyyy) _____ Age: _____ Marital Status: _____

Referred by: _____

Occupation: _____

Physician: _____ Phone : _____

Physician Address : _____

Emergency Contact: _____ Phone : _____

MAIN COMPLAINT (symptoms, diagnosis, duration, etc.):

SIGNIFICANT TRAUMA (physical or emotional)

SURGERIES (please include date of procedure):

KNOWN ALLERGIES (chemical, environmental, food, drug, etc.)

VITAMINS, SUPPLEMENTS, HERBS:

PERSONAL HISTORY

☐ Arthritis	☐ Seizures	☐ Impotence	☐ Infertility
☐ High/Low Blood Pressure	☐ Liver/Gall Bladder Diseas	☐ Stroke	☐ Heart Disease
☐ Diabetes	☐ Food Allergies/Intolerance	☐ Kidney disease	☐ Elev. Blood Cholesterol
☐ Ulcer	☐ Hepatitis	☐ Diverticulitis/IBS	☐ Hypo/Hyperglycemia
☐ Chronic Fatigue	☐ Anemia	☐ Cancer	☐ Raynaud's Disease
☐ Alcoholism	☐ Lyme Disease	☐ Thyroid Imbalance	☐ Respiratory Allergies
☐ Gastritis / Pancreatitis	☐ Asthma	☐ Chronic Pain Condition	☐ Emphysema

FAMILY MEDICAL HISTORY: * Please note which member of the family

☐ Diabetes	_____	☐ Heart Disease	_____
☐ High Blood Pressure	_____	☐ Cancer	_____
☐ Seizures	_____	☐ Stroke	_____
☐ Allergies	_____	☐ Asthma	_____

☐ Other _____

GENERAL

☐ Poor Appetite	☐ Poor Sleep	☐ Fatigue
☐ Chills	☐ Night Sweats	☐ Sweats easily
☐ Fevers	☐ Localized Weakness	☐ Poor Balance
☐ Bleeds/Bruise easily	☐ Weight loss/gain	☐ Dental /Gum problems
☐ Peculiar tastes/smells	☐ Cravings	☐ Muscle Weakness / fatigue
☐ Sudden energy drop	☐ Change in appetite	☐ Tremors
☐ Strong thirst (for hot or cold drinks?)		

SKIN AND HAIR

☐ Rashes	☐ Ulcerations	☐ Hives/Allergic Dermatitis	☐ Itching
☐ Eczema/Psoriasis	☐ Dandruff	☐ Loss of Hair	☐ Recent moles
☐ Skin Discoloration	☐ Acne	☐ Change of hair/skin texture	☐ Face Flushing
☐ Dermatitis	☐ Wart	☐ Fungal Infection	☐ Weak or ridged nails

HEAD, EYES, EARS, NOSE, AND THROAT

☐ Dizziness	☐ Cataracts	☐ Earaches	☐ Jaw clicks/locks
☐ Night Blindness	☐ Blurred Vision	☐ Nose bleeds	☐ Grinding teeth
☐ Eye Strain	☐ Spots in front of eyes	☐ Sinus problems	☐ Migraines
☐ Color Blindness	☐ Glasses	☐ Difficult swallowing	☐ Headaches
☐ Eye Pain	☐ Poor hearing	☐ Dental problems	☐ Facial Pain
☐ Poor Vision	☐ Ringing in ears	☐ Sores on lips/tongue	☐ Recurrent sore throats/ colds

CARDIOVASCULAR

☐ Chest pain or pressure	☐ Irregular heart bbeat	☐ Palpitations at rest	☐ Fainting
☐ Cold hands/feet	☐ Swelling of hands /feet	☐ Blood clots	☐ Phlebitis
☐ Shortness of breath	☐ Varicose/spider veins	☐ Pressure in chest	☐ High Blood Pressure
☐ Low blood pressure	☐ Spontaneous sweating	☐ Dizziness	

RESPIRATORY

☐ Cough/wheezing	☐ Coughing bblood	☐ Production of phlegm
☐ Asthma	☐ Bronchitis	What color? _____
☐ Pneumonia	☐ Pain with deep inhalation	☐ Difficult inhale/exhale
☐ Difficulty breathing when lying down		☐ Tight sensation in chest

GASTROINTESTINAL

☐ Nausea	☐ Poor appetite	☐ Significant thirst	☐ IBS/Crohn's Disease
☐ Gas	☐ Vomiting	☐ Diarrhea	☐ Constipation
☐ Belching	☐ Bad breath	☐ Blood in stool	☐ Chronic laxative use
☐ Indigestion	☐ Rectal pain	☐ Black stools	☐ Hemorroids
☐ Changes in appetite	☐ Bloating/Edema	☐ Loose stools (>2 per day)	☐ Hernia
☐ Excessive appetite	☐ Abdominal Pain	☐ Acid reflux/GERD	

GENITO-URINARY

☐ Pain on urination	☐ Urinary tract infection	☐ Nocturnal emission	☐ Burning urination
☐ Frequent urination	☐ Scanty flow of urine	☐ Decreased libido	☐ Kidney stones
☐ Unable to hold urine	☐ Copious flow	☐ Excessive libido	☐ Pain in testicles
☐ Blood in urine	☐ Impotence	☐ Sores on genitals	☐ Herpes
☐ Urgent urination	☐ Premature ejaculation	☐ Dribbbling after urination	☐ Infections
			☐ Prostatitis

☐ Night urination What time? _____ How often? _____

GYNECOLOGICAL/REPRODUCTIVE

☐ Difficult/Painful intercourse	☐ Ovarian cysts	☐ Age of first menses	_____
☐ Vaginal dryness	☐ Endometriosis	☐ Date of last menses	_____
☐ Vaginal sores	☐ Uterine Fibroids	☐ Date of last PAP/Pelvic	_____
☐ Vaginal discharge	☐ Fibrocystic breast tissue	☐ Number of Pregnancies	_____
☐ PMS	☐ Polycystic Ovarian disease	☐ Number of Ectopic Pregnancies	_____
☐ Irregular menstruation	☐ Infertility	☐ Number of live births	_____
☐ Painful menstruation		☐ Number of miscarriages	_____
		☐ Number of Abortions	_____

Do you practice birth control? _____ What type? _____

How long have you been using this method? _____

MUSCULOSKELETAL:

☐ Neck pain	☐ Muscle pain	☐ Foot/ankle pain
☐ Knee pain	☐ Hand/wrist pain	☐ Tendonitis
☐ Hip pain	☐ Sciatica	☐ Bursitis
☐ Shoulder pain	☐ Muscle weakness	☐ Rotator cuff
☐ Sprains/strains	☐ Carpal Tunnel	

☐ Soreness/weakness in lower body (back, knee, hip, ankle)

☐ Back pain ◯ Low ◯ Middle ◯ Upper

NEUROPSYCHOLOGICAL

☐ Seizures	☐ Nervousness	☐ Depression
☐ Lack of coordination	☐ Loss of Balance	☐ Poor memory
☐ Concussion	☐ Areas of numbness	☐ Bad temper/irritable
☐ Anxiety/Panic attacks	☐ ADD/ADHD	☐ Manic Depression
☐ Easily susceptible to stress	☐ Vertigo/Dizziness	☐ Seasonal affective disorder

Have you ever been treated for emotional problems?	◯ Yes	◯ No
Have you ever considered or attempted suicide?	◯ Yes	◯ No
Have you ever been treated for substance abuse?	◯ Yes	◯ No

COMMENTS: please list any other issues you would like to discuss.

All information provided on this form will be confidential, and will only be used by Inspired. Wellness Center .

Print & bring to your app

Once you print the filled form, close the browser window.

INSPIRED. WELLNESS CENTER