New Patient Intake & Health History Form

If you have any questions regarding this form or your first appointment, please feel free to contact me at **jlholmes526@gmail.com** or **(303)347-1271**. I very much look forward to working with you!

Full Name

Date of Birth

Address

Phone Number(s)

If necessary, may I send mail to your address?

- Yes
- No

May I leave voicemails at the phone number you provided?

- Yes
- No

Would you like to be contacted for appointments reminders?

- Yes
- No

How would you like to be contacted?

- Call
- Text
- None

Are you coming in for general wellness or to address a specific health concern(s)?

- General wellness
- Specific concern
- Both

Primary Concern

What makes it feel better? What makes it feel worse?

Secondary Concern

What makes it feel better? What makes it feel worse?

Have you seen a physician/healthcare provider for this?

- Yes
- No

Were you given a diagnosis/treatment? Was it helpful?

Please list any medications and approximate dosages.

Please list any major health events (traumas, surgeries, hospitalizations, pregnancies and births) with approximate dates (month/year).

Please list any significant/relevant family medical history (ex. cancer, heart disease, strokes, high blood pressure, etc.)

When did you last have a full medical exam from a physician or nurse practitioner (approx. date)?

Do any of these pertain to you NOW or IN THE PAST?

- [ ] Currently pregnant
- [ ] Possibly pregnant
- [ ] Currently breastfeeding
- [ ] Concussions or head injuries
- [ ] Seizures
- [ ] Cancer
- [ ] Radiation, chemotherapy
- [ ] Diabetes
- [ ] Bleeding disorder
- [ ] Hepatitis
- [ ] HIV
- [ ] Lyme Disease, tick-borne illness
- [ ] Herpes
- [ ] Shingles
- [ ] Multiple Sclerosis
- [ ] Thyroid disorder
- [ ] Autoimmune disorder
- [ ] PTSD
- [ ] Abuse or trauma
- [ ] Significant weight change
- [ ] Disordered eating
- [ ] Substance abuse, addiction
- [ ] Caffeine use
- [ ] Alcohol use
- [ ] Nicotine use
- [ ] Marijuana use
- [ ] Recreational drug use
- [ ] Drink soda often

HEAD, EYES, EARS, NOSE, THROAT – check symptoms you currently have OR have had in the last 6 months.

- [ ] Headaches, migraines
- [ ] Dizziness, vertigo
- [ ] Pronounced hair loss
- [ ] Facial pain
- [ ] Jaw tension, pain
- [ ] Teeth grinding
- [ ] Sinus problems
- [ ] Frequent colds
- [ ] Hay fever, seasonal allergies
- [ ] Nosebleeds
- [ ] Ear aches
- [ ] Poor hearing
- [ ] Ear ringing, high pitch
- [ ] Ear ringing, low pitch
- [ ] Eye strain
- [ ] Glasses, contacts
- [ ] Blurry vision, floaters
- [ ] Itchy eyes
- [ ] Watery eyes
- [ ] Red eyes
- [ ] Poor night vision
- [ ] Painful or bleeding gums
- [ ] Tooth pain
- [ ] Frequent cavities
- [ ] Enlarged glands/tonsils
- [ ] Sore/dry throat
- [ ] Plum pit feeling in throat
- [ ] Mouth sores, ulcers
- [ ] Excess saliva

SKIN & HAIR – check symptoms you currently have OR have had in the last 6 months.

- [ ] Acne
- [ ] Boils
- [ ] Cysts, lipoma
- [ ] Rosacea
- [ ] Eczema
- [ ] Bruise easily
- [ ] Rashes
- [ ] Dry skin
- [ ] Itchy skin
- [ ] Sensitive skin
- [ ] Fungal infections
- [ ] Sores that won't heal
- [ ] Mole removal
- [ ] Skin cancer
- [ ] Dandruff
- [ ] Hair loss
- [ ] Rapid graying of hair
- [ ] Change in skin/hair texture

BODY TEMP & SWEAT – check symptoms you currently have OR have had in the last 6 months.

- [ ] Feel warm/hot frequently
- [ ] Hot flashes
- [ ] Feel cold frequently
- [ ] Cold hands & feet
- [ ] Hot hands & feet
- [ ] Sweaty hands/feet
- [ ] Profuse sweating
- [ ] Night sweating
- [ ] Chills

MUSCLES, JOINTS & BONES – check symptoms you currently have OR have had in the last 6 months.

- [ ] Head pain
- [ ] Neck pain
- [ ] Shoulder pain
- [ ] Arm pain
- [ ] Hand/wrist/finger pain
- [ ] Upper back pain
- [ ] Mid-back pain
- [ ] Lower back pain
- [ ] Hip pain
- [ ] Rib pain
- [ ] Groin pain
- [ ] Upper leg pain
- [ ] Side of leg pain
- [ ] Lower leg pain
- [ ] Knee pain
- [ ] Foot/ankle/toe pain
- [ ] Swollen joints
- [ ] Generalized joint pain
- [ ] Generalized muscle weakness
- [ ] Full body aches & pains
- [ ] Numbness, tingling
- [ ] Cramps
- [ ] Tremors
- [ ] Paralysis

CARDIOVASCULAR, CIRCULATORY – check symptoms/conditions you currently have OR have had in the last 6 months.

- [ ] Pacemaker
- [ ] Bleeding disorder
- [ ] Currently taking blood thinning meds
- [ ] High blood pressure
- [ ] Low blood pressure
- [ ] Chest pain
- [ ] Pain over/under heart
- [ ] Left arm pain
- [ ] Fainting
- [ ] Heart palpitations
- [ ] Rapid or irregular heartbeat
- [ ] Poor circulation
- [ ] Previous heart attack
- [ ] Swelling of hands and/or feet
- [ ] Hardening of arteries
- [ ] Phlebitis
- [ ] Varicose veins

RESPIRATORY – check symptoms/conditions you currently have OR have had in the last 6 months.

- [ ] Shortness of breath, wheezing
- [ ] Asthma
- [ ] Bronchitis
- [ ] Pneumonia
- [ ] Chest congestion/phlegm
- [ ] Chest tightness
- [ ] Difficulty inhaling
- [ ] Difficulty exhaling
- [ ] Hoarseness
- [ ] Persistent dry cough
- [ ] Persistent wet cough
- [ ] Postnasal drip

GASTROINTESTINAL – check symptoms you currently have OR have had in the last 6 months.

- [ ] Difficulty swallowing
- [ ] Distention of abdomen
- [ ] Bloating
- [ ] Belching
- [ ] Gas
- [ ] Constipation
- [ ] Diarrhea
- [ ] Indigestion
- [ ] Bad breath
- [ ] Gallbladder trouble
- [ ] Stomach ulcer
- [ ] Heartburn
- [ ] Acid reflux
- [ ] Upper abdominal pain/cramping
- [ ] Lower abdominal pain/cramping
- [ ] Frequent hiccups
- [ ] Nausea
- [ ] Vomiting
- [ ] Hemorrhoids
- [ ] Rectal pain
- [ ] Urgency with bowel movements
- [ ] Waking early due to bowel movements

DIET -- Do you follow any specific dietary philosophies or have any dietary restrictions? Please describe.

THIRST & APPETITE – check symptoms you currently have OR have had in the last 6 months.

- [ ] Low appetite
- [ ] Hungry "all the time"
- [ ] Intense cravings
- [ ] Excessive thirst
- [ ] Disinterest in drinking fluids
- [ ] Nausea after drinking fluids
- [ ] Prefer iced/cold drinks
- [ ] Prefer warm/hot drinks

GENITOURINARY – check symptoms you currently have OR have had in the last 6 months.

- [ ] Frequent urination
- [ ] Incomplete urination
- [ ] Inability to control urine, dribbling
- [ ] Urgency with urination
- [ ] Waking at night to urinate
- [ ] Decreased flow/power
- [ ] Painful urination
- [ ] Burning urination
- [ ] Blood and/or pus in urine
- [ ] Urinary tract infections
- [ ] Kidney infections, stones
- [ ] Smelly and/or dark yellow urine
- [ ] Prostate troubles
- [ ] Penile discharge
- [ ] Erection difficulties
- [ ] Low semen volume
- [ ] Genital itching
- [ ] Genital sores

SEXUAL/REPRODUCTIVE HEALTH – check symptoms you currently have OR have had in the last 6 months.

- [ ] Fertility troubles
- [ ] STD/STI
- [ ] Increased libido
- [ ] Decreased libido
- [ ] Painful intercourse

OBGYN – check diagnoses you have been given OR symptoms you have experienced in the last 6 months.

- [ ] Currently pregnant
- [ ] Currently NO menstrual cycle
- [ ] Postmenopausal
- [ ] Clots in menstrual blood
- [ ] Heavy menstrual flow
- [ ] Light menstrual flow
- [ ] Dark quality
- [ ] Light quality
- [ ] Mixed quality
- [ ] PMS symptoms
- [ ] Irregular cycles (fluctuating length)
- [ ] Abdominal cramps with menses
- [ ] Low back pain with menses
- [ ] Digestive changes with menses
- [ ] Vaginal pain
- [ ] Itching of vulva
- [ ] Vaginal dryness
- [ ] Vaginal discharge
- [ ] Recurrent yeast infections
- [ ] Uterine fibroids
- [ ] Uterine fibroids
- [ ] Endometriosis
- [ ] Ovarian cysts
- [ ] Polycystic Ovarian Syndrome
- [ ] Pelvic Inflammatory Disorder
- [ ] Previous pregnancy
- [ ] Previous miscarriage
- [ ] Menopause symptoms

Date of Last Menstrual Period

Number of days between cycles?

How many days do you bleed?

Mid-cycle bleeding or spotting?

- ( ) Yes
- ( ) No

SLEEP – check symptoms you currently have OR have had in the last 6 months.

- [ ] Difficulty falling asleep
- [ ] Difficulty staying asleep
- [ ] Interrupted/"light" sleep
- [ ] "Night owl" - fall asleep after midnight
- [ ] Wake up feeling tired or groggy
- [ ] Waking to urinate
- [ ] Waking with dreaming
- [ ] Vivid dreams
- [ ] Nightmares, disturbing dreams
- [ ] Use of sleep medications/supplements

How would your rate your energy level on a scale of 1-10, with 10 being the highest?

EXERCISE – are you getting regular exercise?

- [ ] Yes
- [ ] No
- [ ] Not recently

If yes, please describe what movement medicine feels good for you.

MENTAL & EMOTIONAL WELLBEING – check symptoms you currently have OR have had in the last 6 months.

- [ ] Difficulty coping with stress
- [ ] Depression
- [ ] Anxiety
- [ ] Difficulty focusing
- [ ] Poor memory
- [ ] Easily startled
- [ ] Major grief or loss
- [ ] Frequent worry
- [ ] Frequent anger
- [ ] Frequent fear
- [ ] Nervousness
- [ ] Irritability
- [ ] Manic/uncontrollable emotions
- [ ] Mental fatigue
- [ ] Feeling overwhelmed by life

Stress level rating on a scale of 1-10, with 10 being highest?

Please list your primary source(s) of stress and their impact.

What preventative care, self-care, and stress management behaviors do you adopt?

Do you require any specific accommodations or assistance? If so, please describe, and I will do my best to meet your needs.

Do you experience fear, anxiety or nervousness with needles?

- [ ] None
- [ ] Minimal
- [ ] Moderate
- [ ] High
- [ ] Needles absolutely terrify me! Other modalities please!