Transformational Medicine

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Office (520) 209-1755

INITIAL INTAKE / FIRST OFFICE CALL

Date: _____ Date of Birth: _____ Email: _____

Full Name: _____ Name Preference: _____

Address: _____

City/St: _____ Zip: _____

Phone #'s H: _____ Cell: _____ W: _____

I would like appointment reminders by: ___ Text ___ Email ___ Both text and email

Who referred you? _____ Occupation: _____

In case of emergency: Name: _____ Phone: _____
Relationship: _____

What do you do for fun? _____

***Notice to individuals with bleeding disorders, pace makers or cancer: For your safety, it is important to alert provider of these conditions.**

What brings you here today? _____

_____

Medical History: (Conditions / illnesses / accidents / injuries / surgeries):

_____

_____

Family History:

Mother: _____

Father: _____

Siblings: _____

What is your current form of family? _____

Medications: _____

_____

Supplements: _____

_____

Allergies or adverse reactions to anything? _____

Social History:

Do you smoke? Y_____ N_____ If yes, how much/for how long? _____

Do you Drink? Y_____ N_____ If yes, how much/how often? _____

Do you exercise? Y_____N_____ If so, what and how often? _____

Describe your sleep: _____

Bowel Habits: Any constipation / diarrhea? _____ For how long? _____

How often do you urinate? _____

However you describe yourself, please answer to the best of your ability.

FOR WOMEN:

If you are still menstruating, describe your cycles: _____

_____

If not, describe your menopause: _____

Pregnancies: How many, # of live births / how was birth and pregnancy for you? _____

_____

What form of birth control have you used in your life: _____

Are you still sexually active? _____Are you happy with your sex life? _____

Do you have regular pelvic exams? _____ Are you having safe sex? _____

Any sexually transmitted diseases? _____ If so, what? _____

For MEN: Are you still sexually active? _____Are you happy with your sex life? _____

Are you having safe sex? _____ Any sexually transmitted diseases? _____

If so, what? _____ Have you had a prostate exam? _____
Have you had PSA Tested? _____, If so when? _____

Is there anything else you would like the doctor to know? _____

_____

BELOW; FOR DR'S USE ONLY

Vitals: BP: _____ Temp: _____Pulse: _____ O2Sat:_____

Constitutional
HEENT
Lymph Nodes
Lungs
Heart
Abdomen
Rectum
Genitalia
Reproductive
Musculoskeletal
Nervous system:
Mental Status
Cranial Nerves
Motor Strength
Sensations (Light touch/sharp/vibrations/position)
Reflexes: Knees: Achilles:
Cerebellar functions, gait

Hippus test:

UA: _____

Any other concerns for follow-up:

_____

_____

Weight: _____

Height:_____