

FLORES HEALTH SERVICES

Dr. Luis Flores, RCSHom

Dr. Rikst Attema, ND

INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ Prov: _____ Area Code: _____

Telephone # (home): _____ (work): _____

E-mail address: _____

Age: _____ Date of Birth: _____ Gender: female ___ male ___

Married: ___ Separated: ___ Divorced: ___ Widowed: ___ Single: ___ Partnership: ___

Live with: Spouse ___ Partner ___ Parents ___ Children ___ Friends ___ Alone ___

Occupation: _____ Hours per week: _____ Retired: _____

How did you hear about our clinic? _____

Emergency contact: _____

Relationship: _____ Phone: _____

Address: _____

Are you currently receiving healthcare? Y N

If yes, where and from whom: _____

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.
Maximum Weight : _____ When: _____

When during the day is your energy the best? _____ worst? _____
On a scale of 1-10 (10 being the most) please rate your: Energy ___ Stress ___

What are your most important health problems? List as many as you can in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

<p style="text-align: center;"><u>Ears</u></p> <p>Impaired hearing? Y N P Ringing? Y N P Earaches? Y N P Dizziness? Y N P Excessive wax? Y N P</p>	<p style="text-align: center;"><u>Mouth and Throat</u></p> <p>Frequent sore throat? Y N P Teeth grinding? Y N P Sore tongue/lips? Y N P Gum problems? Y N P Hoarseness? Y N P Dental cavities? Y N P</p>
<p style="text-align: center;"><u>Cardiovascular</u></p> <p>Angina? Y N P High/Low Blood Pressure? Y N P Murmurs? Y N P Blood clots? Y N P Fainting? Y N P</p>	<p style="text-align: center;"><u>Blood / Peripheral Vascular</u></p> <p>Easy bleeding or bruising? Y N P Anemia? Y N P Deep leg pain? Y N P Cold hands/feet? Y N P Varicose veins? Y N P</p>
<p style="text-align: center;"><u>Endocrine</u></p> <p>Heat or cold intolerance? Y N P Excessive thirst? Y N P Excessive hunger? Y N P Fatigue? Y N P Seasonal depression? Y N P</p>	<p style="text-align: center;"><u>Immune</u></p> <p>Reactions to immunizations? Y N P Chronic infections? Y N P Chronically swollen glands? Y N P Slow wound healing? Y N P Night Sweats? Y N P</p>
<p style="text-align: center;"><u>Mental / Emotional</u></p> <p>Depression? Y N P Mood Swings? Y N P Anxiety or nervousness? Y N P Considered/Attempted suicide? Y N P Poor concentration? Y N P Memory problems? Y N P</p>	<p style="text-align: center;"><u>Neurologic</u></p> <p>Muscle weakness? Y N P Numbness or tingling? Y N P Loss of memory? Y N P Vertigo or dizziness? Y N P</p>
<p style="text-align: center;"><u>Skin</u></p> <p>Rashes? Y N P Eczema, Hives? Y N P Acne, Boils? Y N P Itching? Y N P Color Change? Y N P Hair Loss? Y N P</p>	<p style="text-align: center;"><u>Musculoskeletal</u></p> <p>Joint pain or stiffness? Y N P Arthritis? Y N P Broken bones? Y N P Weakness? Y N P Muscle spasms or cramps? Y N P Sciatica? Y N P</p>
<p style="text-align: center;"><u>Respiratory</u></p> <p>Cough? Y N P Sputum? Y N P Asthma? Y N P Bronchitis? Y N P Difficulty breathing? Y N P Pain on breathing? Y N P Shortness of breath? Y N P</p>	<p style="text-align: center;"><u>Gastrointestinal</u></p> <p>Trouble swallowing? Y N P Heartburn? Y N P Ulcer? Y N P Abdominal pain or cramps? Y N P Change in appetite? Y N P Belching or passing gas? Y N P Nausea/vomiting Y N P Constipation? Y N P Diarrhea? Y N P Hemorrhoids? Y N P</p>
<p style="text-align: center;"><u>Urinary</u></p> <p>Frequent infections? Y N Pain on urination? Y N P Increased frequency? Y N P Frequency at night? Y N P Inability to hold urine? Y N P Kidney stones? Y N P</p>	

Female Reproduction

Age of first menses? _____
Are cycles regular? _____ Y N
Length of cycle? _____ days
Duration of menses? _____ days
Date of last annual exam/ PAP _____
Hx Abnormal PAP? _____ Y N P
PMS? _____ Y N P
If yes, what symptoms? _____

Painful menses? _____ Y N P
Clotting? _____ Y N P
Heavy or excessive flow? _____ Y N P
Are you sexually active? _____ Y N
Birth control? _____ Y N P

Type? _____
Number of pregnancies: _____
Number of miscarriages: _____
Number of abortions: _____
Difficulty conceiving? _____ Y N P
Sexual difficulties? _____ Y N P
Pain with intercourse? _____ Y N P
STDs? _____ Y N P
(Chlamydia, Gonorrhea, Herpes, Syphilis, Warts)

Age of last menses? (if menopausal) _____
Menopausal symptoms? _____ Y N P
If yes, what symptoms? _____

Male Reproduction

Hernias? _____ Y N P
Testicular masses? _____ Y N P
Testicular pain? _____ Y N P
Discharge or sores? _____ Y N P
Are you sexually active? _____ Y N
Birth control? _____ Y N
Type? _____
Sexual difficulties? _____ Y N P
Impotence? _____ Y N P
Premature ejaculation? _____ Y N P
STDs? _____ Y N P
(Chlamydia, Gonorrhea, Herpes, Syphilis, Warts)

Lifestyle

Do you exercise? _____ Y N
If yes, what kind? _____

How often? _____
Average 6-8 hrs. sleep? _____ Y N
Sleep well? _____ Y N
Awake rested? _____ Y N
Use recreational drugs? _____ Y N P
Use alcoholic beverages? _____ Y N P
Do you use tobacco? _____ Y N P
How many years? _____

How many packs per day? _____
Do you drink cola/other sodas? _____ Y N P
Do you drink coffee? Black tea? _____ Y N P
How many cups per day? _____
Do you drink water? _____ Y N P
How many cups per day? _____
How many bowel movements per day? _____

Is there anything else you would like to add?

Thank you for your time and effort. We look forward to providing you with the best possible care.