1255 W Diversey Parkway
Chicago, IL 60614
312.462.0488

Initial Intake Form

Name: _____
Last First MI

Mailing Address: _____

City: _____ State: _____ Zip: _____

Email address: _____

Phone # (H)_____ (C) _____ (other)_____

Date of Birth: _____ Sex: ❑ Male ❑ Female

Occupation: _____ Employer: _____

How did you hear about us? _____

Health History

PRESENTING PROBLEM AND CURRENT TREATMENT PLAN:

_____

_____

_____

SECONDARY HEALTH ISSUES

_____

_____

_____

Please check to indicate if you have ever had any of the following:

❑ Aids/HIV	❑ Anemia	❑Arthritis	❑ Blood Disease	❑ Cancer
❑ Cataracts	❑ Colds(frequent)	❑ Diabetes	❑ Digestive Problems	❑ Eczema
❑ Epilepsy	❑ Headaches	❑Hepatitis	❑ Herniated Disc	❑ Herpes
❑ Hypertension	❑ High Cholesterol	❑ Kidney Disease	❑ Liver Disease	❑ Lyme
❑ Miscarriage	❑ Pneumonia	❑ Prostate Problems	❑ Rheumatoid Arthritis	❑Stroke
❑ Tumors/Growth	❑ Tuberculosis	❑ Ulcers	❑ Urinary Tract Infections	❑Venereal Disease

Please list any medications you are currently taking (**Be sure to include dosage/frequency**)_____

_____

_____

_____

_____

_____

_____

Please list any supplements you are currently taking (vitamins/herbs/minerals): _____

_____

_____

_____

_____

Please list any allergies (medication/food/insects,ect): _____

_____

Do you exercise: ❑Never ❑Daily ❑ Weekly ❑Walks ❑Runs ❑Swims

Women's Health: Last menstrual cycle:_____

Number of Pregnancies:_____ Number of Children: _____ Number of Miscarriages: _____

Any sexual difficulties?_____

Men's Health: Last Prostate Exam: _____

Any sexual difficulties? _____

Please continue to next page

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Review of Systems

Please mark if you have experienced any of these symptoms within the last 6 months:

Y	N	
		Neurological
		Migraines
		Headaches
		Slurring of speech
		Ringing in Ear
		Ear/Nose/Throat
		Altered taste/smell
		Night Blindness
		Sore Throat
		Gingivitis
		Nose bleeds
		Cardiovascular
		Chest pain
		Palpitations-racing heart beat
		Swelling in hands/feet
		Anemia
		Respiratory
		Recurrent Respiratory Infections
		Asthma
		Chest Congestion
		Wheezing
		Frequent Sneezing
		GI
		Stomach Pains or Cramping
		Constipation
		Reflux or Heartburn
		Bloating
		Gas
		Nausea or Vomiting
		Musculoskeletal
		Joint Pain
		Arthritis
		Chronic pain
		Muscle Aches

Y	N	
		Skin
		Eczema
		Dermatitis
		Excessive Sweating
		Rashes
		Brittle Nails
		Hair Loss
		Easy Bruising
		Increased Bleeding
___	___	Numbness/tingling
		Genitourinary
		Uterine fibroids
		Ovarian cysts
		Cancer (breast, ovarian, prostate, uterine)
		Prostate problems
		Emotional/Mental
		Depression
		Anxiety
		Mood Swings
		Irritability
		Memory Loss
		Confusion
		Energy
		Fatigue
		Hyperactivity
		Restlessness
		Insomnia
		Decreased Libido
		Stress
		Weight
		Decreased Appetite
		Weight Gain
		Inability to Lose Weight
		Food Cravings
		Binge Eating
		Water Retention

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I certify that the above questions were answered accurately. I understand that providing incorrect information can be dangerous to my health.

Print Name: _____

SIGNATURE (X) _____ DATE _____

By typing your name on the above line, you are signing this Agreement electronically. You agree your electronic signature is the legal equivalent of your manual signature on this Agreement. Information given by you in this document is true and correct to the best of your knowledge. You understand and agree that you didn't provide any false information, misrepresentation, or omission of facts