ARTHRITIS Health

Comprehensive Care

Rheumatology • Naturopathy • Acupuncture • Yoga Therapy

9097 E. Desert Cove
Scottsdale, AZ
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Patient Intake Form

Patient Name:_____ Date:_____DOB:_____

Street Address:_____

City:_____ State:_____ Zip:_____

Home phone: _____Work Phone:_____Cell Phone:_____

Highest level of education:_____

Occupation:_____Employer_____Hrs work per week:_____

Marital Status (circle):

Single Married Separated Divorced With Partner Widow(er)

Insurance Company:_____Policy:_____Group #:_____

Name of Insured_____Relation to Insured_____

Social Security Number:_____

Person to call in case of Emergency:_____Relationship to you:_____

Phone number contact for them:_____

Regular Physician: _____

How did you hear of Arthritis Health:_____

List in Order of Importance what your problems are:

1._____
2._____
3._____
4._____
5._____

Last time you had blood work done and with what doctor:_____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	____	_____	_____	_____	_____
Age when died	_____	____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	Y N	Y N	Y N	Y N	Y N	Y N
High BP	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please Note When and Why You Had Each of The Following:

X-rays: _____
MRI/Cat Scans:_____
Ultrasounds:_____
Accidents:_____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____
Foods: _____
Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles:	D I N	Diptheria:	D I N
Mumps:	D I N	Tetanus:	D I N
Rubella:	D I N	Whooping Cough:	D I N
Chickenpox:	D I N	Hemophilus (Hib):	D I N
German Measles:	D I N	Hepatitis B:	D I N

Any vaccination reactions:_____

List Yes, No, or Past regarding use of the following:

Antacids: Y N P
Steroids: Y N P
Smoking: Y N P
Packs per day if Yes/Past:_____
Analgesics: Y N P
Laxatives: Y N P
Coffee: Y N P
Cups per day if Yes/Past:_____
Soda Pop: Y N P
Ounces per day if Yes/Past:_____
Alcohol: Y N P
How often and how much if Yes/Past:_____
Any alcohol addiction: Y N P
Any alcohol treatment: Y N P
Recreational drugs: Y N P
Any drugs addiction: Y N P
Any drug treatment: Y N P

List all Prescription Medicines and Nutrient Supplement/Herbs Taking:

Review of Systems:

Present Weight:_____Weight one year ago:_____
Height: _____ Maximum weight and when:_____
Minimum Weight as adult and when: _____
Ideal Weight:_____

REGARDING THE NEXT LONG SECTION: Please Circle
Y if you have the problem **NOW**, **N** if you've **NEVER** had the problem, **P** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst?:_____
If you have fatigue, can you do what you need to during the day?: Y N

Skin:

Rash: Y N P
Hives: Y N P
Psoriasis/eczema: Y N P
Dry: Y N P
Cancer: Y N P
Color Change: Y N P
Lump: Y N P
Itchy: Y N P
Warts/moles: Y N P
Perspiration: Y N P

Head:

Headache: Y N P
Dandruff: Y N P
Oil/dry hair: Y N P
Migraine: Y N P
Head Injury: Y N P
Hair loss: Y N P

Eyes:

Dry/Watery: Y N P
Double vision: Y N P
Glaucoma: Y N P
Strain: Y N P
Itchy: Y N P
Blurry vision: Y N P
Cataracts: Y N P
Styes: Y N P
Discharge: Y N P
Dark under eyelid: Y N P

Nose:

Frequent colds: Y N P
Congestion: Y N P
Polyps: Y N P
Nosebleeds: Y N P
Post nasal drip: Y N P
Seasonal allergies: Y N P

Mouth/Throat:

Canker sores: Y N P
Sore throat: Y N P
Dentures: Y N P
Loss of taste: Y N P
Cold sores: Y N P
Gum disease: Y N P
Cavities: Y N P
Hoarseness: Y N P

Neck:

Stiffness: Y N P
Swollen glands: Y N P
Full movement: Y N P
Tension: Y N P

Respiratory:

Cough: Y N P
TB: Y N P
Shortness of breath with exertion: Y N P
Bronchitis: Y N P
Shortness of breath sitting: Y N P
Pneumonia: Y N P
Shortness of breath lying down: Y N P
Asthma: Y N P
Wheezing: Y N P
Painful breathing: Y N P

Cardiovascular:

High blood pressure: Y N P
Rheumatic Fever: Y N P
Low blood pressure: Y N P
Murmurs: Y N P
Arrhythmias: Y N P
Palpitations: Y N P
Edema: Y N P
Chest pain: Y N P

Gastrointestinal:

Heartburn: Y N P
Bowel movement frequency:_____
Indigestion: Y N P
Recent change in BM: Y N P
Bloating: Y N P
Diarrhea or constipation: Y N P
Nausea: Y N P
Hemorrhoids: Y N P
Vomiting: Y N P
Gall bladder disease: Y N P
Change in Appetite: Y N P
Liver disease: Y N P
Pancreatitis: Y N P
Ulcer: Y N P

Urinary Tract:

Incontinence: Y N P
Pain with urination: Y N P
Frequent infections: Y N P
Kidney stones: Y N P
Urgency: Y N P
Discharge/blood: Y N P

Male Genitalia:

Testicular pain/swelling: Y N P
Sexually active: Y N P
Hernia: Y N P
Sexually transmitted dz: Y N P
Discharge: Y N P
Prostate dz/symptoms: Y N P
Impotency: Y N P
Sex orientation: Hetero Homo Bi

Female Genitalia:

Age periods began:_____
How frequent:_____
How long periods last: _____
Menopausal since age:_____
Periods:
Times Pregnant:_____
Heavy Bleeding: Y N P
How many births:_____
Cramping: Y N P
Miscarriages:_____
Pain: Y N P
Abortions:_____
PMS: Y N P
Sexual Active: Y N P
Food Cravings: Y N P
Healthy Libido: Y N P

Last Pap Smear:_____ Pain With Intercourse: Y N P
Diagnosis: _____ Dry Vagina: Y N P
Any abnormal paps: Y N P Vaginitis: Y N P
When was abnormal: Y N P
Any Birth Control (please list types and ages used):_____
Sexually Transmitted Diseases: Y N P
Mammography: Y N P
Dexa Scan: Y N P If Yes, what were the results:_____
Use of Hormones: Y N P

Musculoskeletal:

Weakness: Y N P Arthritis: Y N P
Stiffness: Y N P Leg cramps: Y N P
Tremors: Y N P Pain: Y N P

Nervous:

Paralysis: Y N P Sciatica: Y N P
Tingling/numbness: Y N P Carpal tunnel syndrome: Y N P
Seizures: Y N P Fainting: Y N P

Mental/Emotional:

Depression: Y N P Anger/irritability: Y N P
Suicidal: Y N P High-strung/tense: Y N P
Anxiety: Y N P Fear/Panic: Y N P

Exercise:

How often:_____
What type(s):_____
For How long:_____

Hobbies:

_____
_____
_____

Sleep:

How long per night: _____
If you wake up frequently, what is the reason: _____
Nightmares: Y N P
Wake refreshed: Y N P
Must Nap during the day: Y N P
Sleep walk: Y N P
Grind Teeth: Y N P
Snore: Y N P

Food:

Appetite Good?: Y N P
Foods crave: _____
Foods Dislike: _____
Foods that don't sit well:_____

Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?:_____
Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?:_____
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?:_____
Are you particularly sensitive to perfumes, gasoline, or other vapors?:_____
Do you use pesticides, herbicides, other chemicals around your home?_____
_____
_____

Social Life:

Enjoy job?: Y N P
Active Spiritual practice: Y N P
Quality of most significant relationship?_____
History of sexual, mental/emotional, physical abuse?: Y N
If so, at what age and by whom?: _____

What is your greatest health concern?_____
How does it limit you the most? _____
How committed are you to making valuable changes: Little Moderately Very