



Comprehensive Care
Rheumatology • Naturopathy • Acupuncture • Yoga Therapy

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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
Full movement: Y N P

Swollen glands: Y N P
Tension: Y N P

Respiratory:

Cough: Y N P
Shortness of breath with exertion: Y N P
Shortness of breath sitting: Y N P
Shortness of breath lying down: Y N P
Wheezing: Y N P

TB: Y N P
Bronchitis: Y N P
Pneumonia: Y N P
Asthma: Y N P
Painful breathing: Y N P

Cardiovascular:

High blood pressure: Y N P
Low blood pressure: Y N P
Arrhythmias: Y N P
Edema: Y N P

Rheumatic Fever: Y N P
Murmurs: Y N P
Palpitations: Y N P
Chest pain: Y N P

Gastrointestinal:

Heartburn: Y N P
Indigestion: Y N P
Bloating: Y N P
Nausea: Y N P
Vomiting: Y N P
Change in Appetite: Y N P
Pancreatitis: Y N P

Bowel movement frequency: _____
Recent change in BM: Y N P
Diarrhea or constipation: Y N P
Hemorrhoids: Y N P
Gall bladder disease: Y N P
Liver disease: Y N P
Ulcer: Y N P

Urinary Tract:

Incontinence: Y N P
Frequent infections: Y N P
Urgency: Y N P

Pain with urination: Y N P
Kidney stones: Y N P
Discharge/blood: Y N P

Male Genitalia:

Testicular pain/swelling: Y N P
Hernia: Y N P
Discharge: Y N P
Impotency: Y N P

Sexually active: Y N P
Sexually transmitted dz: Y N P
Prostate dz/symptoms: Y N P
Sex orientation: Hetero Homo Bi

Female Genitalia:

Age periods began: _____
How long periods last: _____
Periods:
Heavy Bleeding: Y N P
Cramping: Y N P
Pain: Y N P
PMS: Y N P
Food Cravings: Y N P

How frequent: _____
Menopausal since age: _____
Times Pregnant: _____
How many births: _____
Miscarriages: _____
Abortions: _____
Sexual Active: Y N P
Healthy Libido: Y N P

Last Pap Smear: _____

Diagnosis: _____

Any abnormal paps: 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

Pain With Intercourse: Y N P

Dry Vagina: Y N P

Vaginitis: Y N P

Musculoskeletal:

Weakness: Y N P

Stiffness: Y N P

Tremors: Y N P

Arthritis: Y N P

Leg cramps: Y N P

Pain: Y N P

Nervous:

Paralysis: Y N P

Tingling/numbness: Y N P

Seizures: Y N P

Sciatica: Y N P

Carpal tunnel syndrome: Y N P

Fainting: Y N P

Mental/Emotional:

Depression: Y N P

Suicidal: Y N P

Anxiety: Y N P

Anger/irritability: Y N P

High-strung/tense: 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