



NEW PATIENT INTAKE FORM

Integrative Health Center

Patient Name: _____ DOB: _____ Date of Service: _____
Age: _____ Gender: _____ Occupation: _____
If patient is under 18 years of age: Name of parent or Guardian _____

GENERAL PATIENT INFORMATION

Address: _____
City _____ State _____ Zip _____

Mailing address: (if different from home address): _____
City _____ State _____ Zip _____

Email Address: _____
Email Correspondence (your email will never be sold, shared or traded)

Would you like to receive a copy of our free newsletter via email? Y or N

Home phone: _____ Work phone _____ Cell phone _____

May we leave a confidential voice message at any of the above numbers? [] No [] Yes
If yes, please specify: [] Home [] Work [] Cell

Are you (please circle): single partnership married separated divorced widowed
Live with (please circle): alone partner parents friends children relatives

List your current health care providers and other specialists that are part of your health care team (includes medical doctors, chiropractors, counselors, massage therapist, physical therapist, acupuncturist):

Table with 2 columns: Name, Profession. Row 1: Primary Care: [] []

Emergency Contact _____
Name: _____ Relationship: _____ Phone#: _____

Current Health Concerns

What are your most important health concerns? List as many as you can, in order of importance to you.

- 1. _____ 5. _____
2. _____ 6. _____
3. _____ 7. _____
4. _____ 8. _____

CONTEXT OF CARE

How did you hear about Ocean Pacific Integrative Health Center? _____
What brought you to our clinic? _____
What expectations do you have of me personally as your physician? _____

What is your present level of commitment to addressing your health concerns? Rate from 0-10, 10 being 100% committed:
1 2 3 4 5 6 7 8 9 10

Is there anything else you would like us to know in order to serve you better? _____

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HEALTH HABITS

Do you drink alcohol? _____ If yes, what type of alcohol and how much? 0-1 drinks/week 1-5 6-10 10+

Do you smoke? _____ If yes, how many packs? _____ If you used to, when did you quit: _____

Total number of years smoking? _____

Do you use chewing tobacco? _____ If yes, how many cans? _____

If you used to, when did you quit: _____ Total number of years? _____

Do you exercise? _____ What form _____

How often?(hours/day and days/week) _____

Do you regularly consume products containing caffeine? (Coffee, tea, soft drinks, or energy drinks) Yes No

If yes, please specify type and quantity/day: _____

How do you relax? _____

What are your primary interests or hobbies? _____

DIET:

Number of meals eaten per day: 1 2 3 more than 3

Typical Breakfast: _____

Typical Lunch: _____

Typical Dinner: _____

List the primary foods **excluded** from your diet: _____

FAMILY HISTORY

Have you or any of your blood relatives had any of the following

Put an X in each box that applies	MOTHER	FATHER	SIBLING	GRAND-MOTHER	GRAND-FATHER
ALLERGIES					
ALZHEIMERS					
ARTHRITIS					
ASTHMA					
CANCER (list type)					
DIABETES					
DRUGS/ALCOHOL USE					
EPILEPSY					
HEART DISEASE					
HIGH BLOOD PRESSURE					
MENTAL HEALTH DISORDER					
OSTEOPOROSIS					
REPRODUCTIVE DISORDER					
SKIN DISORDER					
STROKE					
THYROID DISORDER					
OTHER (please list)					

Patient Signature: _____ Date: _____

Confidential