Heart Spring Health

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Patient Demographic Intake Form

Full Legal Name:_____ Date: _____

Address: _____ City: _____ State: _____ Zip code: _____

Phone: Day/_____ Evening/ _____ Cell/ _____ Message OK: ❑ Y ❑ N

E-mail: _____ Age: _____ Date of birth: _____

• What is your birth sex? ❑ Male ❑ Female ❑ Other (please specify)_____

• What gender do you identify as? ❑ Male ❑ Female ❑ Other (please specify)_____

• What is your preferred pronoun? ❑ He ❑ She ❑ Other (please specify)_____

• Marital status: ❑ Married ❑ Partnered ❑ Separated ❑ Divorced ❑ Widowed ❑ Single

• Housing: ❑ Spouse/Partner ❑ Parents ❑ Children ❑ Friend/Roommate ❑ Alone

Occupation: _____ Hours per week: _____ Retired: ❑ Y ❑ N

Emergency contact: _____ Relationship: _____

Phone: _____ E-mail: _____

• How did you hear about us? ❑ Insurance ❑ Walking by ❑ Website

❑ Blog ❑ Event (please specify) _____ ❑ Referred by _____

Medical History (Please fill in as completely as possible)

Allergies

Are you hypersensitive or allergic to:

• Any drugs? _____

• Any foods? _____

• Any environmental agents or chemicals? _____

•Any immunizations? _____

Medications

• Please list any prescription medications, over-the-counter medications, vitamins, supplements, and herbs you are currently taking. Please list doses and frequency.

1. _____ 6. _____
2. _____ 7. _____
3. _____ 8. _____
4. _____ 9. _____
5. _____ 10. _____

Chief Complaint

• For what health problem are you seeking help today? _____

_____

• What other health concerns do you have?

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

• What are your short-term and long-term goals for receiving care at Heart Spring Health?

_____

_____

• Which behaviors or lifestyle habits do you regularly engage in that you believe support your health?

_____

_____

• Which that inhibit your health? _____

_____

Health Care

• Are you currently receiving health care? ❑ Y ❑ N

• If yes, where and from whom? _____

• If no, when and where did you last receive medical care? _____

• What was the reason? _____

• Check the types of providers you have seen before:

❑ Naturopath ❑ Acupuncturist ❑ Physical Therapist

❑ Chiropractor ❑ Massage Therapist ❑ Chiropractor ❑ Therapist/Counselor

Stress and Resiliency

• How have you dealt with hard times in the past? Now? _____

_____

• Have you experienced periods of significant depression, anxiety, drug or alcohol abuse, or other difficulties in coping? When?

_____

_____

• What is restful and restorative for you? _____

_____

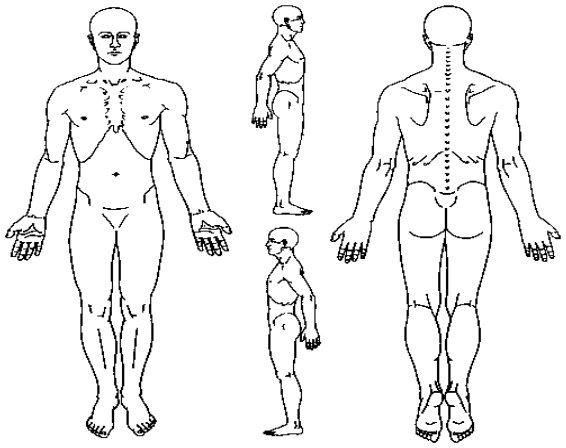
• What do you most enjoy about your life? Least? _____

_____

• What role, if any, does faith or spirituality play in your life? _____

_____

• If you are experiencing pain, please indicate on the diagram below.



Use the following to describe your symptoms:

A = Ache
B = Burning
N = Numbness
P = Pins & Needles
S = Stabbing
R = Sharp
O = Other

Any additional information:

_____
_____
_____
_____
_____

Medical History

Please note specific age and/or year. For imaging, please specify X-rays, MRI's, ultrasounds, CAT scans, or other.

	Infancy	Childhood	Adolescence	Young adulthood	Middle age	Elder years
Hospitalizations						
Surgeries						
Imaging						
Significant health and life events						

Have you ever had…

• Colonoscopy? ❑ Y ❑ N ❑ Abnormal results Date of most recent: _____

• PAP? ❑ Y ❑ N ❑ Abnormal results Date of most recent: _____

• Mammogram? ❑ Y ❑ N ❑ Abnormal results Date of most recent: _____

• DEXA? ❑ Y ❑ N ❑ Abnormal results Date of most recent: _____

• Labs? ❑ Y ❑ N ❑ Abnormal results Date of most recent: _____

• Were you born vaginally? ❑ Y ❑ N • Premature? ❑ Y ❑ N • Adopted? ❑ Y ❑ N

Habits/Environment

• Do you enjoy your work? ❑ Y ❑ N

• Do you exercise? ❑ Y ❑ N

• If yes, what kind? _____

• How many days/wk? _____

• For how long? _____

• Sleep well? ❑ Y ❑ N

• How many hours/night _____

• What are your favorite foods? _____

_____

• Do you follow a special diet? ❑ Y ❑ N

• Are there foods you avoid? ❑ Y ❑ N

• If so, what are they? _____

• What foods do you crave? _____

• Daily water intake: _____ounces per day.

• Exposure to toxins? ❑ Y ❑ N

• Do you or have you ever used tobacco? ❑ Y ❑ N

• Have you quit? ❑ Y ❑ N

• If so, date of last tobacco? _____

• Think about quitting? ❑ Y ❑ N

• Smoked for how many years? _____

• How many packs per day? _____

• Drink alcohol? ❑ Y ❑ N

• Amount: _____

• Use recreational drugs? ❑ Y ❑ N

Family History

Do you have a family history of any of the following?

Disease	Self	Mother	Father	Maternal Grandma	Maternal Grandpa	Paternal Grandma	Paternal Grandpa	Other (specify)
Cancer (specify type)								
Diabetes								
Heart Disease								
High Blood Pressure								
Kidney Disease								
Stroke								
Arthritis								
Autoimmune Disease								
Epilepsy								
Mental illness								
Tuberculosis								
Glaucoma								
Anemia								
Asthma								

General Review of Systems

❑ Y = Yes, ❑ N = No, ❑ P = Past

General

Weight gain	❑ Y ❑ N ❑ P	Weight loss	❑ Y ❑ N ❑ P	Night sweat	❑ Y ❑ N ❑ P

Head

Headaches (HA's)	❑ Y ❑ N ❑ P	HA's with nausea	❑ Y ❑ N ❑ P	Dizziness	❑ Y ❑ N ❑ P
HA's affecting vision	❑ Y ❑ N ❑ P	Head injury	❑ Y ❑ N ❑ P	Jaw problems	❑ Y ❑ N ❑ P

Eyes

Impaired vision	❑ Y ❑ N ❑ P	Eye pain	❑ Y ❑ N ❑ P	Dryness	❑ Y ❑ N ❑ P
Cataracts	❑ Y ❑ N ❑ P	Tearing	❑ Y ❑ N ❑ P	Glaucoma	❑ Y ❑ N ❑ P

Ears

Hearing loss	❑ Y ❑ N ❑ P	Ear pain	❑ Y ❑ N ❑ P	Ringing	❑ Y ❑ N ❑ P

Nose and Sinuses

Frequent colds	❑ Y ❑ N ❑ P	Stuffiness	❑ Y ❑ N ❑ P	Runny nose	❑ Y ❑ N ❑ P
Sinus pain	❑ Y ❑ N ❑ P	Nosebleeds	❑ Y ❑ N ❑ P	Loss of smell	❑ Y ❑ N ❑ P

Mouth and Throat

Frequent sore throat	❑ Y ❑ N ❑ P	Jaw clenching	❑ Y ❑ N ❑ P	Hoarseness	❑ Y ❑ N ❑ P
Teeth grinding	❑ Y ❑ N ❑ P	Oral herpes	❑ Y ❑ N ❑ P	Sores on tongue	❑ Y ❑ N ❑ P

Neck

Trouble swallowing	❑ Y ❑ N ❑ P	Lumps	❑ Y ❑ N ❑ P	Stiffness	❑ Y ❑ N ❑ P
Swollen glands	❑ Y ❑ N ❑ P	Pain	❑ Y ❑ N ❑ P		

Respiratory

Cough	❑ Y ❑ N ❑ P	Pain w/breathing	❑ Y ❑ N ❑ P	Difficulty breathing	❑Y ❑ N ❑ P
Coughing up blood	❑ Y ❑ N ❑ P	Tuberculosis	❑ Y ❑ N ❑ P	" w/exercise	❑Y ❑ N ❑ P
Asthma	❑ Y ❑ N ❑ P	Phlegm	❑ Y ❑ N ❑ P	" lying down	❑Y ❑ N ❑ P
Pneumonia	❑ Y ❑ N ❑ P	Wheezing	❑ Y ❑ N ❑ P		
Emphysema	❑ Y ❑ N ❑ P	Bronchitis	❑ Y ❑ N ❑ P		

Cardiovascular

Chest pain	❑ Y ❑ N ❑ P	Irregular heartbeat	❑ Y ❑ N ❑ P	Heart disease	❑ Y ❑ N ❑ P
High blood pressure	❑ Y ❑ N ❑ P	Rheumatic fever	❑ Y ❑ N ❑ P	Murmurs	❑ Y ❑ N ❑ P
Low blood pressure	❑ Y ❑ N ❑ P	Swelling in ankles	❑ Y ❑ N ❑ P	Calf pain	❑ Y ❑ N ❑ P

Gastrointestinal

Heartburn	❑ Y ❑ N ❑ P	Diarrhea	❑ Y ❑ N ❑ P	Liver disease	❑ Y ❑ N ❑ P
Acid reflux	❑ Y ❑ N ❑ P	Abdominal pain	❑ Y ❑ N ❑ P	Mucous in stool	❑ Y ❑ N ❑ P
Low appetite	❑ Y ❑ N ❑ P	Gas	❑ Y ❑ N ❑ P	Spitting up blood	❑ Y ❑ N ❑ P
Nausea/vomiting	❑ Y ❑ N ❑ P	Bloating	❑ Y ❑ N ❑ P	Undigested food	❑ Y ❑ N ❑ P
Hemorrhoids	❑ Y ❑ N ❑ P	Ulcer	❑ Y ❑ N ❑ P	Blood in stool	❑ Y ❑ N ❑ P
Constipation/straining	❑ Y ❑ N ❑ P	Gallbladder disease	❑ Y ❑ N ❑ P	Black stool	❑ Y ❑ N ❑ P
Loose or narrow stool	❑ Y ❑ N ❑ P	• How many bowel movements a day/week? _____			

Urinary

Urgency	❑ Y ❑ N ❑ P	Hesitancy	❑ Y ❑ N ❑ P	Incontinence	❑ Y ❑ N ❑ P
Increased frequency	❑ Y ❑ N ❑ P	Dribbling	❑ Y ❑ N ❑ P	Kidney stones	❑ Y ❑ N ❑ P
Cloudy urine	❑ Y ❑ N ❑ P	Frequent infections	❑ Y ❑ N ❑ P	Urinating at night	❑ Y ❑ N ❑ P
Blood in urine	❑ Y ❑ N ❑ P	Unusual urine color	❑ Y ❑ N ❑ P	Pain w/urination	❑ Y ❑ N ❑ P

Reproductive

Sexually active	❑ Y ❑ N ❑ P	STI	❑ Y ❑ N ❑ P	Genital discharge	❑ Y ❑ N ❑ P
• Sexual orientation: _____		• Please specify: _____		Genital sores/lumps	❑ Y ❑ N ❑ P
_____		Painful intercourse	❑ Y ❑ N ❑ P	Genital itching	❑ Y ❑ N ❑ P
Birth control	❑ Y ❑ N ❑ P	Sexual difficulties	❑ Y ❑ N ❑ P		
• What type: _____		Difficulty conceiving	❑ Y ❑ N ❑ P		

Female Reproductive

• Age of first menses: _____		Painful menses	❑ Y ❑ N ❑ P	Abnormal PAP	❑ Y ❑ N ❑ P
• Age of final menses: _____		Heavy flow	❑ Y ❑ N ❑ P	•When: _____	
• Length of cycle: _____days		• _____ pads/tampons per day		•# of pregnancies: _____	
• Duration of menses: _____ days		PMS	❑ Y ❑ N ❑ P	•# of miscarriages: _____	
Cycles irregular	❑ Y ❑ N ❑ P	• Explain symptoms: _____		•# of abortions: _____	
Bleeding between	❑ Y ❑ N ❑ P	_____			
Clotting	❑ Y ❑ N ❑ P	• Date of last exam/PAP: _____			
Uterine fibroids	❑ Y ❑ N ❑ P	Menopausal issues	❑ Y ❑ N ❑ P	Ovarian cysts	❑ Y ❑ N ❑ P
Endometriosis	❑ Y ❑ N ❑ P	Breast self-exams	❑ Y ❑ N ❑ P	Breast lumps	❑ Y ❑ N ❑ P
Cervical dysplasia	❑ Y ❑ N ❑ P	Breast tenderness	❑ Y ❑ N ❑ P	Nipple discharge	❑ Y ❑ N ❑ P

Male Reproductive

Hernia	❑ Y ❑ N ❑ P	Erectile dysfunction	❑ Y ❑ N ❑ P	Testicular lumps	❑ Y ❑ N ❑ P
Testicular pain	❑ Y ❑ N ❑ P	Premature ejaculation	❑ Y ❑ N ❑ P	Prostate disease	❑ Y ❑ N ❑ P

Musculoskeletal

Joint pain	❑ Y ❑ N ❑ P	Arthritis	❑ Y ❑ N ❑ P	Gout	❑ Y ❑ N ❑ P
Stiffness	❑ Y ❑ N ❑ P	Weakness	❑ Y ❑ N ❑ P	Muscle spasms	❑ Y ❑ N ❑ P
Broken bones	❑ Y ❑ N ❑ P				

Peripheral Vascular

Easy bleeding	❑ Y ❑ N ❑ P	Varicose veins	❑ Y ❑ N ❑ P	Cold hands/feet	❑ Y ❑ N ❑ P
Easy bruising	❑ Y ❑ N ❑ P	Blood clots	❑ Y ❑ N ❑ P	Anemia	❑ Y ❑ N ❑ P
Deep leg pain	❑ Y ❑ N ❑ P	Leg cramping	❑ Y ❑ N ❑ P	Past transfusions	❑ Y ❑ N ❑ P

Immune

Chronic infections	❑ Y ❑ N ❑ P	Autoimmune disease	❑ Y ❑ N ❑ P	Slow healing	❑ Y ❑ N ❑ P

Endocrine

Hypo/hyperthyroid	❑ Y ❑ N ❑ P	Cravings	❑ Y ❑ N ❑ P	Heat intolerance	❑ Y ❑ N ❑ P
Blood sugar issues	❑ Y ❑ N ❑ P	Excess sweating	❑ Y ❑ N ❑ P	Cold intolerance	❑ Y ❑ N ❑ P
Excess thirst	❑ Y ❑ N ❑ P	Chronic fatigue	❑ Y ❑ N ❑ P	Diabetes	❑ Y ❑ N ❑ P

Neurologic

Fainting	❑ Y ❑ N ❑ P	Memory loss	❑ Y ❑ N ❑ P	Easily stressed	❑ Y ❑ N ❑ P
Paralysis	❑ Y ❑ N ❑ P	Seizures	❑ Y ❑ N ❑ P	Loss of balance	❑ Y ❑ N ❑ P
Numbness or tingling	❑ Y ❑ N ❑ P	Tremors/twitches	❑ Y ❑ N ❑ P		

Skin

Rashes	❑ Y ❑ N ❑ P	Lumps, bumps	❑ Y ❑ N ❑ P	Itching	❑ Y ❑ N ❑ P
Acne, boils, sores	❑ Y ❑ N ❑ P	Eczema	❑ Y ❑ N ❑ P	Hair loss	❑ Y ❑ N ❑ P
Mole changes	❑ Y ❑ N ❑ P	Hives	❑ Y ❑ N ❑ P		

Mental/Emotional

Mood swings	❑ Y ❑ N ❑ P	History of abuse	❑ Y ❑ N ❑ P	Major traumas	❑ Y ❑ N ❑ P
Considered suicide	❑ Y ❑ N ❑ P	Depression	❑ Y ❑ N ❑ P	Binge eating	❑ Y ❑ N ❑ P
Attempted suicide	❑ Y ❑ N ❑ P	Anxiety	❑ Y ❑ N ❑ P	Anorexia	❑ Y ❑ N ❑ P
Poor concentration	❑ Y ❑ N ❑ P	Tension	❑ Y ❑ N ❑ P		