# Patient Intake and History

## For children skip sections that don't apply.

Name: DOB:

If child parents names:

***I give permission for Dr. Johnson and staff to answer my medical questions on email: Yes No _____***

***I want to receive the office newsletter when active YES NO***

_____

**What health problems would you like to address on your initial visit? Please rank by priority: Example: Headache - fatigue - back pain**

1. _____ 4._____

2. _____ 5._____

3._____ 6:_____

Other:_____

**Immunization history: ( consider copy of records) List topics to discuss:**

**Birth History (children) include type of birth** or complications:

**Brief pediatric health history ( for children under 12):**

**Medical Conditions: (circle or type yes in box)**

| **Food allergies/ sensitivities**<br><br>**yeast overgrowth** | **Environmental allergies/ sensitivities**<br><br>**eczema/psoriasis** | **Depression/anxiety**<br><br>**Other psychiatric** |
|---|---|---|
| heart disease or CHF<br><br>high blood pressure | cancer:Type and treatment | lyme related disease<br><br>memory loss |
| migraine headaches<br><br>ADD/Aspergers | osteoarthritis<br><br>COPD | fibromyalgia<br><br>sleep apnea |
| asthma<br><br>diabetes Typer 1 or 2<br><br>other: | rheumatoid arthritis<br><br>hepatitis<br><br>other: | thyroid disease<br><br>HIV<br><br>other: |

Are you a smoker (years))_____

Describe alcohol habits _____

Describe any drug use or addictions:

List all allergies to medicines, foods and allergens with reaction/symptoms:

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

More:_____

**FAMILY MEDICAL HISTORY: (Place appropriate letter and age (F=father, M=mother, S=sibling, G=grandparent):**

**Surgical History or Special Treatments (List surgeries and Dates):**

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

Other:_____

## Please List all Prescription Medications and dosages:

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

**Other**

**Do you have med side effects or concerns?**

## Please list all vitamins, supplements, herbs your taking:

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

**Comments**:

**Are you:** Single - Married - In a Relationship - Sexual Preference

(optional):_____

**If in a relationship is it supportive? Does it impact mental/physical health (Optional)?**

**List the major stressors in your life ?**

**What physical activity do you participate in, and how often?**

**Describe your  sleep habits and general vitality**:

**Describe and diet issues or history:**

***Please expand on any health related issues or questions here. Also, if there are any typical, chronic or concerning health symptoms you would like to address of make us aware of please list here. Chronic symptoms can often be a clue to underlying issues.**