COMPLETE WELLNESS

Breakdowns to Breakthroughs, Disorder to Wellness

30 E. 60th Street #302 - New York, NY 10022
www.completewellnessnyc.com
(office) (212) 737-9000 | (fax) (212) 223-5700

Patient Intake Form

(OFFICE USE ONLY)

☐ **New Patient**	Notes:
☐ **Special Consultation**	For:

Full Name (First, Last)			**Date**
Referral: How did you hear about us? Who should we Thank? (Full name)	**DOB**	**Age**	☐ **Male** ☐ **Female**
Home Address	**Apt #**	**Mobile Number**	
City		**State**	**Zip**
Employer		**Work Number**	
Work Address		**City**	**State** / **Zip**
Social Security Number		**Email Address**	
Emergency Contact Name		**Relationship**	**Emergency Contact Number**

Insurance Information

Primary Insurance Carrier	**Group Number**	**ID Number**
Primary Insured	**Employer Name**	
Business Address		
Employee Social Security Number	**Employee Date of Birth**	

Primary Health Concerns

Please use the following to best describe the primary reason you are seeking medical care today.

Concern	Symptoms	Onset/Duration

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Symptoms

Please use the following to best describe your primary issues and when they began or how long they have been a concern

Health Issue	Symptoms	Onset/Duration

Medications and Supplements

Please list all medications and supplements that you take on a regular basis.

Medication	Supplement Purpose	Dose	Frequency	Response

Allergies

Please list any allergies to supplements, medications, foods, or environmental substances:

Allergy	Reaction

Medical History

Please detail any hospitalizations and/or surgeries you have had:

Reason for Hospitalization &/or Surgery	Outcome	Date

Please detail any hospitalizations and/or surgeries you have had:

Illness	Date of Onset	Date of Resolution

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Are you presently under the care of a physician, chiropractor, naturopath, acupuncturist, or other health practitioner?

Practitioner	Specialty	Location	Telephone

Women

Age of menstrual onset?		Last menstrual period?		Are your periods regular?	
Days between periods?		Duration of period?		Number of pregnancies/children?	

Health Maintenance

Please list the date of the most recent of the following, and bring whatever results you may have with you to your appointment.

	Date		Date		Date
Complete physical		Vision test		**WOMEN:**	
EKG		Tetanus booster		Pap smear	
Cardiac stress test		Hepatitis B vaccine		Mammogram	
MRI/CT				Breast Exam	
X-rays		**MEN:**		Bone density	
Dental		Prostatic exam			
Cholesterol test		PSA blood test		**CHILDREN:**	
Stool blood test		Bone density		Immunizations	
Colonoscopy					

Personal Habits

TOBACCO:

Do you currently or have you ever smoked?		If yes, what?			
How much?		How long?		When did you quit?	

ALCOHOL:

Do you currently drink alcohol?		If so, what and how often?	
Have you ever had a drinking problem?		If yes, how long sober?	
Do you still regularly attend meetings of any kind?		What kind of meeting?	

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RECREATIONAL DRUGS:

Do you use recreational drugs?		If so, which ones?	
Have you ever used intravenous drugs?		If yes, when was the last time?	
Have you ever been treated for a drug problem?		Are you still in treatment?	

EXERCISE:

Do you currently exercise?		How often?		Session Length?	
What exercise do you do?					

MISCELLANEOUS:

Do you drink coffee?		How many 8 ounce cups per day?			
Do you take laxatives?		Which kinds?		How often?	
Do you use antacids?		Which kinds?		How often?	
How many hours of sleep do you get each night?			Do you feel rested in the am?		
Do you have problems falling or staying asleep?			Do you have night sweats?		
Do you wake frequently?		What time?			
Are you sexually active?		Do you use condoms during sexual intercourse?			

Family History

Please list ages, health problems and cause of death if deceased:

Family Member	Living (age)	Health Issue(s)	Deceased (age)	Cause
Mother				
Father				
Brother(s)				
Sister(s)				
Maternal Grandmother				
Maternal Grandfather				
Paternal Grandmother				
Paternal Grandfather				

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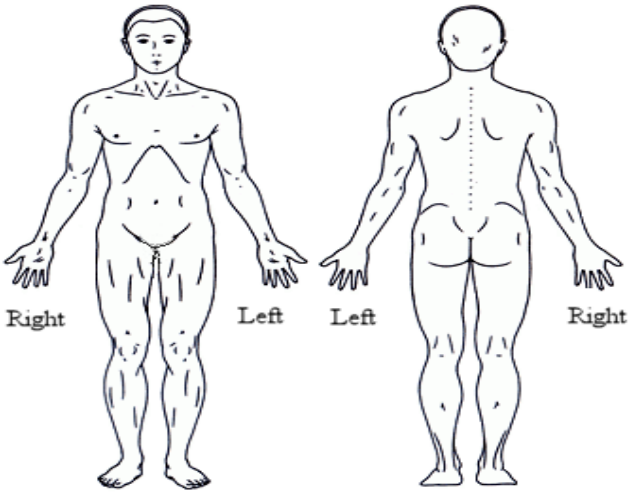
Please circle your pain (no pain) 0 1 2 3 4 5 6 7 8 9 10 (worse pain)

The pain is:

□ Sharp
□ Stabbing
□ Burning
□ Shooting
□ Electric
□ Throbbing
□ Dull
□ Moving
□ Fixed
□ Constant
□ Intermittent
□ Cramping
□ Aching

Using the symbols below, mark on the pictures where you feel pain

Pain: x
Numbness: o



What makes the pain WORSE:

□ Pressure
□ Stretching
□ Exercise
□ Other
□ Cold
□ Heat
Sitting
□ Lying
□ Standing
□ Walking

What makes the pain BETTER:

□ Pressure
□ Stretching
□ Exercise
□ Other
□ Cold
□ Heat
□ Sitting
□ Lying
□ Standing
□ Walking

Have you ever had an accident?

□ Auto _____/_____ (Mo./Yr)
□ Other _____/_____ (Mo./Yr)
□ Work _____/_____ (Mo./Yr)
□ None

How do these conditions impair your daily activities? _____

_____

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Symptoms	Present	Past
Anxiety		
Arthritis		
Asthma		
Bleeding Disorder		
Blood Thinning Medication		
Cancer		
Carpal Tunnel		
Chest Pains		
Cold Hands/Feet		
Constipation		
Depression		
Diabetes		
Diarrhea		
Digestive/Stomach Upset		
Dizziness		
Epilepsy		
Fatigue		
Headaches		
Heart Disease		
Heartburn/Reflux		
Hepatitis		
High Blood Pressure		
High Fever		
HIV		
Hormone Imbalance		
Irritability		
Jaws/TMJ problems		
Joint Swelling		
Kidney Disease		

Symptoms	Present	Past
Lights Bother Eyes		
Loss of Balance		
Menopause		
Menstrual Cramps		
Metal Implants		
Muscular Aches		
Loss of Memory		
Neck Pain		
Neck Stiff		
Neurologic Disorders		
Pacemaker		
Pain between Shoulders		
Pain in Hands or Arms		
Pain in Legs/Ankle/Feet		
Ringing in Ears		
Seizures		
Shortness of Breath		
Sinus Issues		
Stress		
Tension		
Tingling/Numbness		
Upper Back pain		
Loss of Smell or Taste		
Sleeping Problems		
Pregnancy		
Shoulder Pain		
Nervousness		
Other_____		
Other_____		

I, _____ hereby certify that the statements and answers given on this form are accurate to the best of knowledge and understand it is my responsibility to inform this office of any changes in my health. I agree to allow this office to examine me for further evaluation.

Patient Name (Print)

Signature	**Date**