

Client Initial Intake

Dr. Katie Swedrock

Name: _____ Date of Birth: _____

List of Complaints (in order of importance):

- 1. _____
- 2. _____
- 3. _____
- 4. _____
- 5. _____

Current Medications and Supplements (include dosage): _____

Previous Surgeries and Hospitalizations (include date): _____

Allergies (Medications and Food): _____

Please list date of your last:

Screening blood Work: _____ Dental Screening: _____ Eye Exam: _____

Please indicate if you have had the disease (D) or were immunized (I)

Measles: D I Mumps: D I Rubella: D I Hemophilis (Hib): D I

Tetanus: D I Shingles: D I Chicken Pox: D I Hepatitis B: D I

Whooping Cough: D I German Measles: D I HPV (Gardasil): D I

Other Vaccinations: _____

Please indicate if you use any of these frequently:

Yes (Y), No (N), or Past history of use (P):

Antacids: Y N P Smoking: Y N P Packs per day & number of years _____

Analgesics: Y N P Coffee: Y N P Cups per day if yes or passed _____

Laxatives: Y N P Alcohol: Y N P Amount if yes or passed _____

Steroids: Y N P Soda: Y N P Amount if yes or passed _____

Recreational Drugs Y N P

Addictions and/or treatment for addictions: Y N P Explain: _____

Height: _____ Current Weight: _____ Ideal Weight: _____

Maximum Weight as Adult: _____ Minimum Weight as adult: _____

Exercise:

How often: _____ Type: _____

Sleep:

Amount: _____ Wake Refreshed? _____

Social Life:

Job: _____ Enjoy Job? _____

Hobbies: _____

Define Religion/Spiritual Status: _____

Relationship: Married Single In a relationship

Satisfied with Significant Relationship? _____

History of Mental/Physical/emotional Abuse? _____

Family History

<u>Family Member</u>	<u>Age if Living</u>	<u>Age of Death</u>	<u>Reason of Death</u>
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			

<u>Disease</u>	<u>Family Member</u>
Heart attack/stroke	
Cancer (include type)	
Mental Illness	
Heart Disease	
High Blood Pressure	
Osteoporosis	
Asthma/allergies	
Autoimmune(RA,Lupus,etc)	
Diabetes	

Review of Systems

Circle Yes (Y), No (N) or diagnosed with or experienced frequently in the past (P):

Skin:

Rash:	Y	N	P	Eczema:	Y	N	P	Color Change:	Y	N	P
Hives:	Y	N	P	Cancer:	Y	N	P	Abnormal Mole:	Y	N	P
Psoriasis:	Y	N	P	Warts:	Y	N	P	Dry/ Itchy:	Y	N	P

Head:

Migraines:	Y	N	P	Dandruff:	Y	N	P	Oily/dry Hair:	Y	N	P
Headache:	Y	N	P	Hair Loss:	Y	N	P	Head Injury:	Y	N	P

Nose:

Nose bleeds:	Y	N	P	Allergies:	Y	N	P	Frequent Colds:	Y	N	P
Polyps:	Y	N	P	Congestion:	Y	N	P	Problems Smelling:	Y	N	P

Eyes:

Dryness:	Y	N	P	Cataracts:	Y	N	P	Pain:	Y	N	P
Itching:	Y	N	P	Glaucoma:	Y	N	P	Watery/Discharge:	Y	N	P
Redness:	Y	N	P	Styes:	Y	N	P	Vision Problems:	Y	N	P

Ears:

Ear infections	Y	N	P	ringing in ears	Y	N	P	Changes in hearing	Y	N	P
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Mouth/Throat/Neck:

Cavities:	Y	N	P	Goiter:	Y	N	P	Problems speaking:	Y	N	P
Dentures:	Y	N	P	Gum Disease:	Y	N	P	Problems tasting:	Y	N	P
Sores:	Y	N	P	Sore throat:	Y	N	P	Problems swallowing:	Y	N	P
Neck Stiffness:	Y	N	P	Swollen Glands:	Y	N	P				

Respiratory:

Asthma:	Y	N	P	Cough:	Y	N	P	Shortness of Breath:	Y	N	P
Emphysema:	Y	N	P	TB:	Y	N	P	Wheezing:	Y	N	P
Pneumonia:	Y	N	P	Bronchitis:	Y	N	P	Pain with Breathing:	Y	N	P

Cardiovascular:

Palpitations:	Y	N	P	Heart Attack:	Y	N	P	High Blood Pressure:	Y	N	P
Chest Pain:	Y	N	P	Rheumatic Fever:	Y	N	P	Arrhythmias:	Y	N	P
Murmurs:	Y	N	P	Edema:	Y	N	P	Low Blood Pressure:	Y	N	P

Urinary Tract:

Incontinence:	Y	N	P	Kidney Stones:	Y	N	P	Frequent Infections:	Y	N	P
Urgency:	Y	N	P	Blood in Urine:	Y	N	P	Pain with Urination:	Y	N	P

Gastrointestinal:

Heartburn: Y N P	Vomiting: Y N P	Change in Appetite: Y N P
Indigestion: Y N P	Ulcers: Y N P	Gall Bladder Disease: Y N P
Gas/Bloating: Y N P	Hemorrhoids: Y N P	Pancreatitis: Y N P
Constipation: Y N P	Liver Disease: Y N P	Stomach Pain: Y N P
Diarrhea: Y N P	Nausea: Y N P	

Male Genitalia:

STD's Y N P	Hernia: Y N P	Erectile Dysfunction: Y N P
Discharge: Y N P	Prostate disease: Y N P	Testicular Pain/swelling: Y N P
Pain: Y N P	Sexually Active: Y N P	Frequent Night urination: Y N P

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Female Genitalia:

Age of First Menses: _____ First Day of Last Menses: _____ Length of Menses: _____

Age of Menopause: _____ Date of Last Mammogram: _____ Results: _____

Date of Last Pap Smear: _____ Results: _____

Date of last Dexa (Bone) Scan: _____ Results: _____

Times Pregnant: _____ Children: _____ Miscarriages: _____ Abortions: _____

Birth control previously or currently used: _____

Sexual Orientation: Heterosexual Homosexual Bisexual Other

Abnormal Paps: Y N P	Discharge: Y N P	Pain with intercourse: Y N P
PMS: Y N P	Odor: Y N P	Healthy Libido: Y N P
STD: Y N P	Heavy Bleeding: Y N P	Sexually Active: Y N P
Vaginitis: Y N P	Vaginal Dryness: Y N P	Menstrual Cramping: Y N P

Musculoskeletal:

Weakness: Y N P	Tremors: Y N P	Leg Cramps: Y N P
Stiffness: Y N P	Arthritis: Y N P	Pain: Y N P

Nervous:

Paralysis: Y N P	Sciatica: Y N P	Numbness/Tingling: Y N P
Seizures: Y N P	Fainting: Y N P	Carpel Tunnel: Y N P

Mental/Emotional:

Depression: Y N P	Suicidal: Y N P	Psych Hospitalization: Y N P
Anxiety: Y N P	Fear/Panic: Y N P	Bipolar: Y N P
Eating Disorder: Y N P	Irritability: Y N P	Obsessive: Y N P