SYNERGY
Integrative Medical Center

PATIENT INFORMATION

NAME: _____

ADDRESS: _____

_____

_____

HOME TELEPHONE: _(_____)_____

CELLULAR TELEPHONE: (_____)_____

WORK TELEPHONE: _(_____)_____

EMAIL ADDRESS: _____

BIRTHDATE: _____/_____/_____

NAME OF PRIMARY CARE PHYSICIAN: _____

EMERGENCY CONTACT: _____**PHONE:**_____

REASON FOR VISIT: _____

How did you hear about us:

Synergy Integrative Medicine
Patient Intake form for Women

MR# _____

Name _____**Age**_____ **Date** _____

Primary Care Doctor _____ **Referred by** _____

Concern(s): Please rank by priority	**Onset**	**Frequency**	**Severity**
Example: Headaches	2 years ago	2x/wk	mild/mod/severe
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

What are your goals for this visit? _____
_____
_____
_____

Illnesses – yours & your family's	**Self**	**Family**	**List family members who have had these illnesses**
Heart Disease	☐	☐	_____
High blood pressure	☐	☐	_____
Cancer	☐	☐	_____
Stroke	☐	☐	_____
Diabetes	☐	☐	_____
Lung disease	☐	☐	_____
Hepatitis	☐	☐	_____
Digestive diseases	☐	☐	_____
Seizures	☐	☐	_____
Thyroid disease	☐	☐	_____
Mental disorders	☐	☐	_____
Osteoporosis	☐	☐	_____
Other _____	☐	☐	_____
Other _____	☐	☐	_____

Number of pregnancies _____ Vaginal births ____ C-sections ____ Miscarriages ____ Terminations ____

Any problems with pregnancies, deliveries or the babies? _____

_____

_____

Currently pregnant? _____ Are you actively trying to conceive? _____ Currently breastfeeding? _____

Last menstrual period _____ or Age at menopause_____

If still menstruating: Cycles every ____ days Days of flow ____

Light, moderate or heavy flow? _____ Clots? _____ Cramps? _____

PMS? no yes describe symptoms _____

Operations		**Injuries**	
What	When	What	When
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please list all medications, vitamins, herbs and supplements which you now take regularly, prescribed or over-the-counter.

Name & dosage	**Reason**	**When started**	**Who recommended**

Allergies or intolerances to medicines/chemicals/foods:

Medication/chemical/food	Reaction/intolerance symptoms

Occupation, or previous occupation if retired: _____

Number of hours worked per week _____

What interests/hobbies do you have? _____

_____

_____

With whom do you live?

Name	Age	Relationship	Name	Age	Relationship

What physical activity do you do? _____

_____

What are the major stressors in your life? _____

_____

_____

What do you do to relax? (or what would you like to do?) _____

_____

_____

Religious affiliation _____

What prior experiences have you had with complementary and alternative medicine? _____

_____

Tobacco use: □ never used □ smoked from age ___ to ___ . ____ packs per day.

Alcohol use: □ never used □ estimated ____ drinks per week.

□ history of alcohol abuse

Recreational drugs: □ never used □ type

_____

Health screening:

Have you had?	No	Yes	Date of most recent	Who ordered/performed
Mammogram				
Colonoscopy				
Pap/pelvic exam				
Bone density test				
Cholesterol screening				

Review of symptoms:

Sleep _____ hrs/night sleep problems _____ do you snore? y n

Sexual problems _____

Hair problems _____

Intolerance to heat or cold (circle if applicable)

Fatigue y n

Dry skin y n

Frequent or severe headaches y n

Weight loss y n Weight gain y n

Swelling y n describe _____

Palpitations y n

Breast pain y n

Hot flashes y n

Frequent crying or depression y n

Weakness y n

Joint pain y n

Muscle problems y n

Stomach/bowel problems y n describe _____

Urinary problems y n describe _____