



**An Integrative Medical Center**

**Ph: (757) 410-5462**

**PATIENT INFORMATION FORM**

**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 (please check):**

**TV** \_\_\_\_\_ **Tidewater Women** \_\_\_\_\_ **Internet** \_\_\_\_\_ **Friend** \_\_\_\_\_ **Other** \_\_\_\_\_

**Synergy Integrative Medical Center**  
**Patient Intake form for WOMEN**

MR# \_\_\_\_\_

Name \_\_\_\_\_

Date \_\_\_\_\_

Primary Care Doctor \_\_\_\_\_

Referred by \_\_\_\_\_

**Concern(s): Please rank by priority**

Example: Headaches

**Onset**

2 years ago

**Frequency**

2x/wk

**Severity**

mild/mod/severe

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

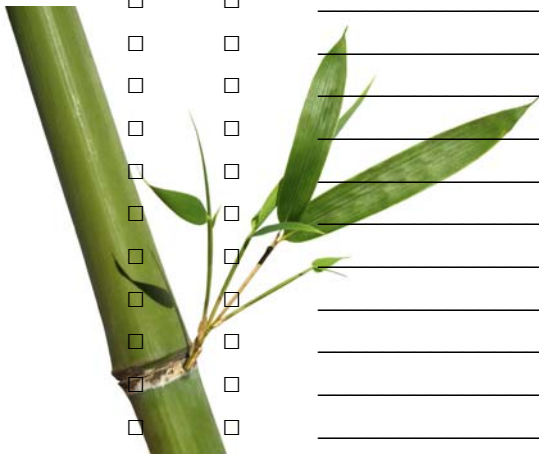
**What are your goals for this visit?** \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Illnesses – yours & your family’s**

**List family members who have had these illnesses**

**Self    Family**

- |                     |                          |                          |       |
|---------------------|--------------------------|--------------------------|-------|
| Heart Disease       | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| High blood pressure | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Cancer              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Stroke              | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Diabetes            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Lung disease        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Hepatitis           | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Digestive diseases  | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Seizures            | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Thyroid disease     | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Mental disorders    | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Osteoporosis        | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |
| Other _____         | <input type="checkbox"/> | <input type="checkbox"/> | _____ |





**Allergies or intolerances to medicines:**

Medication

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 4 describe \_\_\_\_\_

