



An Integrative Medicine Center for Women

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 Medicine
PATIENT INTAKE FORM

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 _____

