Phelps M.D.
INTEGRATIVE MEDICINE

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Patient Intake Form

Name ***Age***

Address

Home Phone	
Cell Phone	
Birthday	

Appt Time/Date ______________________________

Prioritize Health Concerns

Priority	Health Concern	Date of Onset	Severity	Frequency
1				
2				
3				
4				
5				

Goals for yourself ____
Describe yourself____
____

Past Medical Problems

Disabilities ____

Health as a child: Any illnesses?/birth injuries?/vaginal delivery or C-Section?_____
____

Past Surgery

Procedure	Date	Any continuing problems?

Meds/Allergies

Allergies to meds/foods/environment?

Allergy	Date of Onset	How do you Treat?

Medications including over the counter

Medicine	Reason	Dose	Frequency	Date started	Side effects

Herbs/supplements/vitamins

Product	Brand	Dose	Reason	Freq	Date start	Side Effec

Experience with alternative/complementary medicine ______________________________
____
____
____

Family History

Are you adopted? Yes/No
Health of immediate family

	Age	State of Health	Diagnosis
Mother			
Father			
Mat GM			
Mat GF			
Pat GM			
Pat GF			
Sibling			
Sibling			
Children			

Lifestyle Concerns

Do you have any Pain?

Where	Scale 1-10 *	Date it started	What makes it better	What makes it worse

*0-no pain/10-worst pain ever

When is your energy level highest? Morning/afternoon/night
Lowest? Morning/afternoon/night

Sleep pattern:

Time to Bed	
Time You Awaken	
How long does it take to get to sleep	
How many hours you sleep	

What happens at night?	
Do you wake up?	
Do you nap? How long?	
Any recent changes?	

Do you dream? Yes/No
Do you remember your dreams? Yes/No
Any recurring dreams? ____

Nutrition history

Any Particular Diet?________________ eating habits___________________________

Body image Good_______________Bad

History or ongoing problem of anorexia/bulimia/other?________________________

Weight/height ___________________ Are you happy with your weight? Yes/No

Weight 5 yr ago_________ Weight at age 21 _____________

Recent weight changes? Yes/No How Much________________

Who prepares your food?____

Eat alone? Yes/No Standing/driving?

Organics?____

Cravings?____

Food dislikes?____

Do you eat out a lot? Yes/No Do you eat fast food? Yes/No

Frequency of Foods:

	None	A Little	Moderate	A Lot
Fruit				
Veggies				
Red Meat				
Poultry				
Fish				
Whole grains				
Beans				
Soy				
Dairy				
Fats				

Substance Use	# years	How much/day	
Alcohol			
Tobacco			
Caffeine			
Other			

Social history:

Who do you live with?____
How is your home life?____
Marital history____
Most positive significant relationships____________________________________
Most negative____
Community?____
Religion/spirituality____
Financial hardships?____
What is a typical day/week for you?______________________________________
____

How many hours in a day do you spend :	Hours spent day or week?	Do you want to increase or decrease?
Work		
Child Rearing		
School		
Exercise		
TV		
Video Game		
Cell phone		

Past work history____
____
Birth place__________________________
Where have you lived and for how long?
____
____

Hobbies/interests____
Do you read? If so, what? (newpaper, magazines, books)
Favorite book/movie/TV show/ music_____________________________________
Volunteer work?____

Do you have any history of mental/physical abuse? Yes/No

Stress Level 1---10(hi stress)
What do you do to relax?____
What are your supports?____
What have your tried?____

Do you have Depression? ____
Important stressful anniversaries-birth/death/accident/losses ________________
____

Traumas that have affected you____
____
PTSD?____

Preventative Health

Exercise program____
History of exercise____

Sun exposure Hrs/day________ Do you wear Sunscreen? Yes/No Type?_____________
Auto safety: seatbelts/carseats
Weapons in house? Yes/No
Smoke detectors? Yes/No
Carbon monoxide detector? Fire extinguisher? (Circle if you have)
Possible Lead Esposure?____________________________
Disaster readiness? Yes/No
Do you feel safe? Yes/N

Labs

Lab	Result	Date

Avg BP ____________________

Immunization history