**Bridges Family Wellness PC**
7831 SE Lake Rd, Suite 102
Milwaukie, OR 97267

# New Patient Intake

## Bridges Family Wellness Intake Form

Full Name: *

Home address: *

Cell Phone *

Other Phone number(s):

Emergency Contact name *

Emergency Contact Phone number *

Insurance information. Please include Company, company phone number, ID number, Group number, name of insured and birthday of insured: *

Referred By: *

Primary Physician *

Preferred Pharmacy:
Please list address including zip code and phone number. *

Do you currently smoke? Have you been a smoker in the past? *

What is your Main Concern? How long has this been a problem? Are you currently receiving any treatments for this issue? *

When and where did you last receive medical care? For what purpose? *

Have you had any surgeries? If so, please list them: *

Have you had any hospitalizations or prolonged periods of immobility? If so, please list them: *

**Bridges Family Wellness PC**
7831 SE Lake Rd, Suite 102
Milwaukie, OR 97267

Have you had any major illnesses? If so, please list them. Examples: Cancer, Diabetes, High Blood pressure, Heart Disease, Hepatitis, Rheumatic Fever, Thyroid Disease, Seizures, etc. *

Do you have any current diagnoses? If so, please list them below: *

Do you have any allergies? If so, please list them: *

Have you had any significant Traumas? If so, please list them: *

Are you currently taking any medications? If so, please list the names and dosages: *

Are you taking any over the counter supplements including herbs and homeopathics? If so, please list them along with their doses: *

Are you up to date on your vaccinations?
If an adult, have you had a tetanus shot in the past 10 years? Do you choose to receive annual flu shots? *

Do you have any occupational stresses (chemical, physical, psychological, etc.) *

Are there any illnesses such as cancer, heart disease, diabetes, thyroid disease, hypertension, high cholesterol, or mental health disorders that run in your family? If so, please list them below: *

What type of exercise do you engage in and how often? *

Do you partake of any of the following substances: Coffee, Tea, Cola, Alcohol, Drugs, Sugar, Salt, Other. If so which and how often? *

What do you typically eat in a 24 hour period? *

Do you have any of the following issues?

Poor appetite,

Heavy appetite,

Change in appetite,

Cravings

Poor Sleep,

Heavy Sleep,

Insomnia,

Fatigue,

Sudden energy drop at a particular time? What time?

Tremors,

Vertigo

Coldness of the hands, feet, back, or abdomen

Fever,

chills,

night sweats,

easy sweating

Localized weakness,

Poor coordination,

Do you have any of the following issues?

Rashes,

Ulcerations,

Hives,

Itching,

Eczema,

Pimples,

Dandruff,

Changes in hair or skin texture,

loss of hair,

purpura (tiny bruises),

or other skin/hair problems? *

Do you have any of the following issues?

Dizziness,

Concussions,

Migraines

Eye strain,

Eye pain,

Poor vision,

spots in eyes,

night blindness,

color blindness,

cataracts,

blurry vision?

Do you wear glasses?

Earaches,

ringing in ears,

poor hearing?

Nose bleeds,

sinus problems,

mucus?

Dry throat,

dry mouth,

copious saliva,

teeth problems,

jaw clicks,

grinding teeth?

Recurrent sore throats?

Gum problems,

sores on lips or tongue?

Facial pain,

Headaches where and when? ______________________________

Do you have any of the following issues? ______________________________

______________________________

High blood pressure

Low blood pressure ______________________________

Chest Pain

Irregular Heartbeat

Dizziness

Fainting

Swelling in hands or feet

Blood Clots

Phlebitis

Difficulty Breathing * ______________________________

**Bridges Family Wellness PC**
7831 SE Lake Rd, Suite 102
Milwaukie, OR 97267

Do you have any of the following issues?

Cough
Coughing blood
Asthma
Bronchitis
Pneumonia
Difficulty Breathing when lying down
Tight chest
Production of phlegm? What color? *

Do you have any of the following issues?

Nausea
Vomiting
Diarrhea
Gas
Belching
Black stools
Bad breath
Rectal pain
Hemorrhoids
Constipation
Bloody stools
Sensitive abdomen
Pain or Cramps
Do you use laxatives? How often
How many bowel movements per day? *

Do you have any of the following issues?

Pain on urination
Frequent urination
Blood in Urine
Urgency to urinate
Unable to hold urine
Kidney stones
Sexually transmitted infection
Erectile Dysfunction
Do you wake to urinate? How many times per night? *

Please answer these questions regarding female

bodies:

Number of pregnancies

Number of births

Premature births

Miscarriages

Birth control type and duration

Age of first menses

Light or heavy flow

How long does your period last

When was your last PAP

When was your last period

Do you experience any of the following:

clots, menopausal symptoms, breast tenderness,

Do you experience any of the following:

Seizures

Areas of Numbness

Poor memory

Concussion

Depression

Anxiety

Bad temper

Easily stressed

Treated for emotional problems

Treated for other neurological problems

Have you considered or attempted suicide? *

What is your preferred season, which do you least prefer? *

What types of taste do you prefer (e.g.. sweet/salty), what is your least favorite? *

What type of climate do you enjoy, what type do you try to avoid? *

What are your best and worst times of the day? *

Do you prefer hot or cold temperatures? *