



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: *



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? *

- | | |
|--|--|
| <input type="checkbox"/> Poor appetite | <input type="checkbox"/> Heavy appetite |
| <input type="checkbox"/> Change in appetite | <input type="checkbox"/> Cravings |
| <input type="checkbox"/> Poor Sleep | <input type="checkbox"/> Heavy Sleep |
| <input type="checkbox"/> Insomnia | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Sudden energy drop at a particular time | <input type="checkbox"/> Tremors |
| <input type="checkbox"/> Vertigo | <input type="checkbox"/> Coldness of the hands, feet, back, or abdomen |
| <input type="checkbox"/> Fever | <input type="checkbox"/> chills |
| <input type="checkbox"/> night sweats | <input type="checkbox"/> easy sweating |
| <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Poor coordination |
| <input type="checkbox"/> Bleeding or Bruising easily | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Others _____ | |

Do you have any of the following issues? *

- | | |
|-----------------------------------|--|
| <input type="checkbox"/> Rashes | <input type="checkbox"/> Ulcerations |
| <input type="checkbox"/> Hives | <input type="checkbox"/> Itching |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Pimples |
| <input type="checkbox"/> Dandruff | <input type="checkbox"/> Changes in hair or skin texture |



- Do you have any of the following issues? *
- | | |
|--|---|
| <input type="checkbox"/> loss of hair | <input type="checkbox"/> purpura (tiny bruises) |
| <input type="checkbox"/> None of the above | |
| <input type="checkbox"/> Others _____ | |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Concussions |
| <input type="checkbox"/> Migraines | <input type="checkbox"/> Eye strain |
| <input type="checkbox"/> Eye pain | <input type="checkbox"/> Poor vision |
| <input type="checkbox"/> spots in eyes | <input type="checkbox"/> night blindness |
| <input type="checkbox"/> color blindness | <input type="checkbox"/> cataracts |
| <input type="checkbox"/> blurry vision | <input type="checkbox"/> wear glasses or contacts |
| <input type="checkbox"/> Earaches | <input type="checkbox"/> ringing in ears |
| <input type="checkbox"/> poor hearing | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> sinus problems | <input type="checkbox"/> mucus |
| <input type="checkbox"/> Dry throat | <input type="checkbox"/> dry mouth |
| <input type="checkbox"/> copious saliva | <input type="checkbox"/> teeth problems |
| <input type="checkbox"/> jaw clicks | <input type="checkbox"/> grinding teeth |
| <input type="checkbox"/> Recurrent sore throats | <input type="checkbox"/> Gum problems |
| <input type="checkbox"/> sores on lips or tongue | <input type="checkbox"/> Facial pain |
| <input type="checkbox"/> Headaches | <input type="checkbox"/> None of the above |
| <input type="checkbox"/> Others _____ | |

- Do you have any of the following issues? *
- | | |
|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Chest Pain | <input type="checkbox"/> Irregular Heartbeat |
| <input type="checkbox"/> Dizziness | <input type="checkbox"/> Fainting |
| <input type="checkbox"/> Swelling in hands or feet | <input type="checkbox"/> Blood Clots |
| <input type="checkbox"/> Phlebitis (inflammation of veins) | <input type="checkbox"/> Difficulty Breathing |
| <input type="checkbox"/> None of the above | |
| <input type="checkbox"/> Others _____ | |

- Do you have any of the following issues? *
- | | |
|--|---|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Coughing blood |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Bronchitis |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Difficulty Breathing when lying down |
| <input type="checkbox"/> Tight chest | <input type="checkbox"/> Production of phlegm |
| <input type="checkbox"/> None of the above | |
| <input type="checkbox"/> Others _____ | |

- Do you have any of the following issues? *
- | | |
|--|--|
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting |
| <input type="checkbox"/> Diarrhea | <input type="checkbox"/> Gas |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Black stools |
| <input type="checkbox"/> Bad breath | <input type="checkbox"/> Rectal pain |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Constipation |
| <input type="checkbox"/> Bloody stools | <input type="checkbox"/> Sensitive abdomen |



- Pain or Cramps
- none of the above
- Others _____
- Do you use laxatives

Do you have any of the following issues? *

- Pain on urination
- Blood in Urine
- Unable to hold urine
- Sexually transmitted infection
- Erectile Dysfunction
- none of the above
- Others _____
- Frequent urination
- Urgency to urinate
- Kidney stones
- Do you practice safer sex
- waking to urinate

Please answer these questions regarding female bodies:

- Have you ever been pregnant
- Are you experiencing menopausal symptoms
- Are you experiencing breast lumps
- Are you experiencing vaginal sores
- Others _____
- Do you use birth control
- Are you experiencing breast tenderness
- Are you experiencing vaginal discharge

Do you experience any of the following: *

- Seizures
- Poor memory
- Depression
- Bad temper
- Treated for emotional problems
- Have you considered or attempted suicide
- Others _____
- Areas of Numbness
- Concussion
- Anxiety
- Easily stressed
- Treated for other neurological problems
- none of the above

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? *
