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

New Patient Intake

Bridges Family Wellness Intake Form

Full Name: *

What is your birthdate? MM/DD/YYYY *

What is your gender identity? *

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 job or hobby related 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 did you eat in the last 24 hours? *

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
- ☐ Tremors

- [ ] Vertigo
- [ ] Coldness of the hands, feet, back, or abdomen
- [ ] Fever
- [ ] chills
- [ ] night sweats
- [ ] easy sweating
- [ ] Localized weakness
- [ ] Poor coordination
- [ ] Bleeding or Bruising easily
- [ ] None of the above
- [ ] Others _____

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)
- [ ] None of the above
- [ ] Others _____

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
- [ ] wear glasses or contacts
- [ ] 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
- [ ] None of the above
- [ ] Others _____

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 (inflammation of veins)
- [ ] Difficulty Breathing
- [ ] None of the above
- [ ] Others _____

Do you have any of the following issues? *

- [ ] Cough
- [ ] Coughing blood

- [ ] Asthma
- [ ] Bronchitis
- [ ] Pneumonia
- [ ] Difficulty Breathing when lying down
- [ ] Tight chest
- [ ] Production of phlegm
- [ ] None of the above
- [ ] Others _____

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
- [ ] none of the above
- [ ] Others _____

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
- [ ] Do you practice safer sex
- [ ] Erectile Dysfunction
- [ ] waking to urinate
- [ ] none of the above
- [ ] Others _____

Please answer these questions regarding female bodies: *

- [ ] These Questions do not apply to me as I do not have a female body.
- [ ] Have you ever been pregnant
- [ ] Do you use birth control
- [ ] Are you experiencing menopausal symptoms
- [ ] Are you experiencing breast tenderness
- [ ] Are you experiencing breast lumps
- [ ] Are you experiencing vaginal discharge
- [ ] Are you experiencing vaginal sores
- [ ] None of the above
- [ ] Others _____

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
- [ ] none of the above
- [ ] Others _____

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? *