TREE OF LIFE WELLNESS

Intake Form

General Information

Name: Age: Prounouns:

Date of Birth: Email:

Address: City:

Phone (Home): Cell:

Background: ☐ African ☐ European ☐ Mediterranean ☐ Asian

☐ Native American ☐ Other ☐ Middle Eastern

When, where and from whom did you last receive medical or health care?

Emergency Contact: Relationship:

Phone (Home): Cell:

Physician (Name): (Phone): (Fax):

How did you hear about the practice?

☐ Clinic website ☐ Referral from doctor ☐ Referral from friend/family member

☐ Social media ☐ Other

Primary Pharmacy

Name: Phone Number:

Address: City: State:

Zip: E-mail: Fax*:

Insurance:

Carrier Name: _____

Enrollee ID/Contract Number: _____

Group Number: _____

Your Health History

Please rank your current and ongoing health concerns in order of priority

1. _____
2. _____
3. _____
4. _____
5. _____

Allergies

Name of Medication/Supplement/Food:	Reaction:
1.	
2.	
3.	
4.	
5.	

Medications/Supplements

Current medications (include prescription and over-the-counter)

Medication	Dosage	Start Date	Reason for Use

Nutritional supplements (vitamins/minerals/herbs etc.)

Name/Brand	Dosage	Start Date	Reason for Use

Have medications or supplements ever caused unusual side effects or problems? If yes, describe: ☐ Yes ☐ No

TREE OF LIFE WELLNESS

Your Medical History (YES = a condition you currently have, PAST = a condition in the past)

Gastrointestinal	Yes	Past
Irritable bowel syndrome	☐	☐
GERD (reflux)	☐	☐
Crohn's disease/ulcerative colitis	☐	☐
Peptic ulcer disease	☐	☐
Celiac disease	☐	☐
Gallstones	☐	☐
Other:	☐	☐
Respiratory		
Bronchitis	☐	☐
Asthma	☐	☐
Emphysema	☐	☐
Pneumonia	☐	☐
Sinusitis	☐	☐
Sleep apnea	☐	☐
Other:	☐	☐
Urinary/Genital		
Kidney stones	☐	☐
Gout	☐	☐
Interstitial cystitis	☐	☐
Frequent yeast infections	☐	☐
Frequent urinary tract infections	☐	☐
Sexual dysfunction	☐	☐
Sexually transmitted diseases	☐	☐
Other:	☐	☐
Endocrine/Metabolic		
Diabetes	☐	☐
Hypothyroidism (low thyroid)	☐	☐
Hyperthyroidism (overactive thyroid)	☐	☐
Polycystic Ovarian Syndrome	☐	☐
Infertility	☐	☐
Metabolic syndrome/insulin resistance	☐	☐
Eating disorder	☐	☐
Hypoglycemia	☐	☐
Other:	☐	☐
Inflammatory/Immune		
Rheumatoid arthritis	☐	☐
Chronic fatigue syndrome	☐	☐
Food allergies	☐	☐
Environmental allergies	☐	☐
Multiple chemical sensitivities	☐	☐
Autoimmune disease	☐	☐
Immune deficiency	☐	☐
Mononucleosis	☐	☐
Hepatitis	☐	☐
Other:	☐	☐

Musculoskeletal	Yes	Past
Fibromyalgia	☐	☐
Osteoarthritis	☐	☐
Chronic pain	☐	☐
Other:	☐	☐
Skin		
Eczema	☐	☐
Psoriasis	☐	☐
Acne	☐	☐
Skin cancer	☐	☐
Other:	☐	☐
Cardiovascular		
Angina	☐	☐
Heart attack	☐	☐
Heart failure	☐	☐
Hypertension (high blood pressure)	☐	☐
Stroke	☐	☐
High blood fats (cholesterol, triglycerides)	☐	☐
Rheumatic fever	☐	☐
Arrythmia (irregular heart rate)	☐	☐
Murmur	☐	☐
Mitral valve prolapse	☐	☐
Other:	☐	☐
Neurologic/Emotional		
Epilepsy/Seizures	☐	☐
ADD/ADHD	☐	☐
Headaches	☐	☐
Migraines	☐	☐
Depression	☐	☐
Anxiety	☐	☐
Autism	☐	☐
Multiple sclerosis	☐	☐
Parkinson's disease	☐	☐
Dementia	☐	☐
Other:	☐	☐
Cancer		
Lung	☐	☐
Breast	☐	☐
Colon	☐	☐
Ovarian	☐	☐
Skin	☐	☐
Other:	☐	☐

Gynecologic and Obstetric History

Menstrual History

Age at first period: Date of last menstrual period:

Length of cycle: Time between cycles:

Length of cycle: ☐ Yes ☐ No Pain? ☐ Yes ☐ No

Have you ever had premenstrual problems (bloating, breast tenderness, irritability, etc.)? ☐ Yes ☐ No

If yes, please describe:

Do you have other problems with your periods (heavy, irregular, spotting, skipping, etc.)? ☐ Yes ☐ No

If yes, please describe:

Use of hormonal birth control: ☐ Birth control pills ☐ Patch ☐ Nuva ring ☐ Other

Any problems with hormonal birth control? ☐ Yes ☐ No

If yes, explain:

Use of other contraception? ☐ Yes ☐ No

☐ Condoms ☐ Diaphragm ☐ IUD ☐ Partner vasectomy

Are you in menopause? ☐ Yes ☐ No If yes, age last period:

Was it surgical menopause? ☐ Yes ☐ No

If yes, explain surgery:

Do you currently have symptomatic problems with menopause? (Check all that apply)

☐Hot flashes ☐Mood swings ☐ Concentration/ memory problems ☐ Headaches ☐Joint pain

☐ Vaginal dryness ☐ Weight gain ☐ Decreased libido problems ☐ Loss of control of urine ☐Palpitations

Are you on hormone replacement therapy? ☐ Yes ☐ No

If yes, for how long and for what reason (hot flashes, osteoporosis prevention, etc.)?

Other Gynecological Symptoms: (Check if applicable)

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe)

Gynecological Screening/Procedures: (If applicable, provide date)

☐ Endometriosis ☐ Infertility ☐ Fibrocystic breasts ☐ Vaginal infection ☐ Fibroids
☐ Ovarian cysts ☐ Pelvic inflammatory disease ☐ Reproductive cancer
☐ Sexually transmitted disease (describe)

Gynecological Screening/Procedures: (If applicable, provide date)

Last Pap test:
Last mammogram:
Last bone density:
Other tests/procedures (list type and dates)

Obstetric History: (Check box and provide number if applicable)

Pregnancies: Miscarriages:
Vaginal deliveries Cesarean:
Birth weight of largest baby:
Birth weight of smallest baby:
Did you develop any problems in or after pregnancy, for example, toxemia (High blood pressure), diabetes, post-partum depression, issues with breast feeding, etc.? ☐ Yes ☐ No
If yes, please explain:

TREE OF LIFE WELLNESS

Family History

Check family members that have/had any of the following

	Mother	Father	Brother (s)	Sister (s)	Child	Child	Child	Child	Maternal Grandmother	Maternal Grandfather	Paternal Grandmother	Paternal Grandfather	Other
Age (if still alive)													
Age at death (if deceased)													
Cancer	o	o	o	o	o	o	o	o	o	o	o	o	o
Heart disease	o	o	o	o	o	o	o	o	o	o	o	o	o
Hypertension	o	o	o	o	o	o	o	o	o	o	o	o	o
Obesity	o	o	o	o	o	o	o	o	o	o	o	o	o
Diabetes	o	o	o	o	o	o	o	o	o	o	o	o	o
Stroke	o	o	o	o	o	o	o	o	o	o	o	o	o
Autoimmune disease	o	o	o	o	o	o	o	o	o	o	o	o	o
Arthritis	o	o	o	o	o	o	o	o	o	o	o	o	o
Kidney disease	o	o	o	o	o	o	o	o	o	o	o	o	o
Thyroid problems	o	o	o	o	o	o	o	o	o	o	o	o	o
Seizures/epilepsy	o	o	o	o	o	o	o	o	o	o	o	o	o
Psychiatric disorders	o	o	o	o	o	o	o	o	o	o	o	o	o
Anxiety	o	o	o	o	o	o	o	o	o	o	o	o	o
Depression	o	o	o	o	o	o	o	o	o	o	o	o	o
Asthma	o	o	o	o	o	o	o	o	o	o	o	o	o
Allergies	o	o	o	o	o	o	o	o	o	o	o	o	o
Eczema	o	o	o	o	o	o	o	o	o	o	o	o	o
ADHD	o	o	o	o	o	o	o	o	o	o	o	o	o
Autism	o	o	o	o	o	o	o	o	o	o	o	o	o
Irritable Bowel Syndrome	o	o	o	o	o	o	o	o	o	o	o	o	o
Dementia	o	o	o	o	o	o	o	o	o	o	o	o	o
Substance abuse	o	o	o	o	o	o	o	o	o	o	o	o	o
Genetic disorders	o	o	o	o	o	o	o	o	o	o	o	o	o
Other:	o	o	o	o	o	o	o	o	o	o	o	o	o