Confidential Patient Intake Form

Elham Ansari BFA AP RYT BCHN
Ayurvedic Medicine / Holistic Nutrition
elham@elhamansari.com

Personal Information

Today's Date:_____

Name: _____

Address: _____

_____

_____

Phone: _____

Email: _____

Contacts

Lifestyle Choices

Habits (please check all that apply, and provide the frequency and amount of use):

☐ Alcohol _____ ☐ Tobacco _____

☐ Caffeine _____ ☐ Sugar _____

☐ Recreational Drugs _____ ☐ Other _____

Diet (please describe your daily diet, indicating which foods you consume most often):

_____

_____

_____

_____

_____

Exercise (please indicate your frequency of exercise):

☐ daily ☐ 3-4 times weekly ☐ 1-2 times weekly ☐ not at all

Please describe your typical routine and/or list your favourite activities:

_____

_____

__

_____

Medical Information

Health Concerns (please briefly describe the reason for today's visit):

_____

_____

_____

Health Conditions (please check all that apply, past and present):

- ☐ AIDS
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Anorexia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bleeding Disorder
- ☐ Bronchitis
- ☐ Bulimia
- ☐ Cancer
- ☐ Candidiasis
- ☐ Cataracts
- ☐ Chicken Pox
- ☐ Chronic Fatigue
- ☐ Chronic Pain
- ☐ Convulsions
- ☐ Depression
- ☐ Diabetes
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Gallbladder problems
- ☐ German Measles
- ☐ Goiter
- ☐ Gout
- ☐ Heart Disease
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Hernia
- ☐ Herpes Simplex 1
- ☐ Herpes Simplex 2
- ☐ High Blood Pressure
- ☐ High Cholesterol
- ☐ Hyperglycemia
- ☐ Hypoglycemia
- ☐ Jaundice
- ☐ Kidney Disorders
- ☐ Liver Disorders
- ☐ Low Blood Pressure
- ☐ Lupus
- ☐ Measles
- ☐ Menstrual Disorders
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Obsessive Compulsive Disorder
- ☐ Osteoarthritis
- ☐ Osteomalacia
- ☐ Osteoporosis
- ☐ Parkinson's
- ☐ Pneumonia
- ☐ Polio
- ☐ Prostate Disorders
- ☐ Psoriasis
- ☐ Psychiatric Care
- ☐ Rheumatic Fever
- ☐ Rheumatoid Arthritis
- ☐ Seizures
- ☐ Stomach Ulcers
- ☐ Stroke
- ☐ Thyroid Disorders
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Urinary Tract Infections
- ☐ Venereal Disease
- ☐ Other_____

Family History:

- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Drug Dependencies
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Obesity
- ☐ Stroke
- ☐ Other_____
- ☐ Other_____

☐ Diabetes ☐ Liver Disease

Allergies (Please list any allergies):

_____

_____

Hospitalizations (Please note circumstances):

_____

_____

Medications and Supplements:

Medication and/or Type Dosage Medications and/or Type Dosage

General
☐ Insomnia
☐ Dream-disturbed sleep
☐ Excessive sleep
☐ Fatigue
☐ Dizziness
☐ Numbness
☐ Frequent chills
☐ Fever
☐ Premature hair loss
☐ Premature greying

Respiratory
☐ Cough
☐ Dry Cough
☐ Cough with phlegm
☐ Cough with blood
☐ Asthma
☐ Shortness of breath
☐ Common Cold
☐ Excessive phlegm

Circulatory
☐ Cold hands and feet
☐ Excessive bleeding
☐ Easy Bruising

Cardiovascular/Chest
☐ Chest pains/tightness
☐ Palpitations
☐ Irregular heartbeat
☐ Rapid heart rate
☐ Blood clotting disorder
☐ Right-sided rib pain

Nervous System
☐ Tremors
☐ Poor balance
☐ Seizures

Musculoskeletal
☐ Muscle cramps
☐ Body aches
☐ Joint pain
☐ Swollen joints
☐ Paralysis
☐ Neck and shoulder tension
☐ Hand and arm pain
☐ Hip and leg pain
☐ Foot and ankle pain
☐ Low back pain
☐ Upper back pain

Mental/Emotional
☐ Depression
☐ Easily stressed
☐ Anger
☐ Irritability
☐ Frequent sighing
☐ Fear
☐ Grief
☐ Worrying
☐ Anxiety
☐ Forgetfulness
☐ Cloudy thinking
☐ Obsessive behaviour
☐ Lack of motivation
☐ Nervous tics

☐ Nasal discharge
☐ Poor sense of smell

☐ Sore throat
☐ Hoarse voice
☐ Difficulty swallowing

th and Throat
☐ Mouth ulcers
☐ Dry mouth/throat
☐ Excessive thirst
☐ Lack of thirst
☐ Teeth pain
☐ Gum problems
☐ TMJ

☐ Ringing in the ears
☐ Poor hearing
☐ Earaches
☐ Ear infection

Skin
☐ Eczema
☐ Psoriasis
☐ Hives
☐ Acne
☐ Fungal infections
☐ Itchy skin
☐ Shingles
☐ Dry skin
☐ Dandruff
☐ Excessive sweating
☐ No sweating
☐ Numbness

Digestive/Excretory
☐ Nausea
☐ Vomiting
☐ Diarrhea
☐ Loose stools
☐ Constipation
☐ No daily bowel movement
☐ Hemorrhoids
☐ Rectal pain
☐ Excessive hunger
☐ Loss of appetite
☐ Weight loss
☐ Weight gain
☐ Abdominal bloating/gas
☐ Belching
☐ Acid reflux
☐ Hiccups
☐ Stomach pain
☐ Abdominal pain
☐ Food allergies/sensitivities

☐ Abuse survivor

Head and Face
☐ Headache
☐ Migraines
☐ Jaw pain
☐ Facial tics
☐ Facial paralysis
☐ Dizziness

Eyes
☐ Degenerating vision
☐ Blurry vision
☐ Night blindness
☐ Visual spots
☐ Red eyes
☐ Eye pain

Nose
☐ Sinusitis
☐ Nasal polyps
☐ Post-nasal drip
☐ Nose bleeds

Urinary/Genital
☐ Urinary tract infections
☐ Kidney stones
☐ Urinary incontinence
☐ Frequent daytime urination
☐ Frequent nighttime urination

Men's Health
☐ Painful urination
☐ Dribbling urination
☐ Foamy urine
☐ Bloody urine
☐ Genital pain
☐ Genital itching
☐ Venereal diseases

☐ Impotence
☐ Infertility
☐ Seminal emissions
☐ Premature ejaculation
☐ Decreased libido

Symptoms (Please check all that apply within the past three months; circle for emphasis):

Women's Health

☐ Painful intercourse ☐ Endometriosis ☐ Decreased libido
☐ Infertility ☐ Vaginal dryness ☐ Other_____

Menstruation:

How many days between periods?_____
Please indicate if you experience any of the following between periods:
☐ Vaginal discharge ☐ Bleeding ☐ Cramps/Pain

How many days in duration are your periods?_____
Please indicate the quality of blood:
☐ Light red ☐ Bright red ☐ Other_____
☐ Dark red ☐ Clotted ☐ Other_____

Please indicate the quantity of blood:
☐ Heavy flow ☐ Normal flow ☐ Scanty flow

If you experience any cramping, please indicate when?
☐ Before menstruation ☐ During menstruation ☐ After menstruation

Do you experience breast tenderness? Y / N
When?_____ Where?_____

Pregnancy:

How many pregnancies have you had?_____
Have you had any miscarriages? Y / N
Indicate any pregnancy-related difficulties:_____
_____

Are you currently pregnant? Y / N
Are you trying to become pregnant? Y / N

Are you currently using contraceptive(s)? Y / N
If yes, what type and for how long:_____

Menopause:

Please indicate your current status:
☐ Premenopausal ☐ Perimenopausal ☐ Postmenopausal

If applicable, at what age did menopause begin?_____
Please indicate any menopause-related symptoms:
☐ Hot flashes ☐ Vaginal dryness ☐ Mood swings
☐ Night sweats ☐ Insomnia ☐ Depression

_____