INTEGRATIVE FUNCTIONAL & REGENERATIVE MEDICINE (SAMPLE INTAKE FORM)

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COMPREHENSIVE CANCER
WELLNESS PROGRAM

Date _____ E-Mail Address _____

First _____ Middle _____ Last _____

Home Address _____

City, State, Zip _____

Home Phone ( ) _____ Cell ( ) _____

Birth Date _____ Current Age _____ S.S.N. _____

Referral Name _____

Marital Status _____ No. of Children _____

Children's Ages _____

Your Occupation _____

Patient's Employer _____

Business Address _____

City, State, Zip _____

Business Phone ( ) _____

Name of Spouse _____ Spouse's S.S.N. _____

Primary Insurance Company _____

Name of Insured _____

Group No. / Policy No. _____

Secondary Insurance Company _____

Group No. / Policy No. _____

I clearly understand and agree that all services rendered to me are charged directly to me, and that I am personally responsible for payment. I also understand that if I suspend or terminate my care and treatment, any fees for professional services rendered to me will be immediately due and payable.

Signature Date _____

Background Information:

Primary Physician _____ Phone _____

Date of Last Physical Exam _____

Abnormal Findings _____

Date of Last Blood Test _____

Abnormal Findings in Blood Test _____

Date of Last PAP Smear (Females Only) _____

Abnormal Findings in PAP (Females Only) _____

Date of last Mammogram (Females Only) _____

Abnormal Findings in Mammogram (Females Only) _____

Present complaint(s) or illness(es):

_____

Illness Duration _____

Events preceding onset:

How long since you've been well _____

Personal Health Goals:

List travel immunizations _____

Recent flu shots _____

Do you have mercury amalgam fillings? _____ If yes, how many? _____

Do you have root canals? _____ If yes, how many? _____

List any Accidents you have had with dates:

List any Surgeries you have had with dates:

Medications that you are currently taking (include birth control pills and non-prescription drugs, including vitamins/supplements). Indicate the dosage, length of time taking the medication, and frequency of use.

Have you ever had a frequent or prolonged use of the following drugs, if so, provide your age at the time and for how you took them?

Antibiotics _____

Antihistamines _____

Cortisone _____

Prednisone _____

Steroids _____

Describe how you feel about these issues (**G**=Great / **O**=Okay / **P**=Problem):

Spouse _____
Significant other _____
Children _____
Work ___
Sex Life _____
Finances _____

Describe how you feel about your life in general:

_____

Do you smoke cigarettes now? _____ Have you smoked? _____

How much? _____ How long? _____

Alcohol Usage: Alcohol Type_____

Alcohol Amount_____ Frequency_____

Do you now or have you ever had a problem with drugs? _____

If yes, describe:_____

How often do you exercise? _____

What type of exercise? _____

For how long? _____

Would you describe your stress levels as low, moderate or high? _____

Describe the kind of work you do:_____

How often do you have bowel movements?_____

What kind of water do you drink? _____

Do you have a purifier? _____ What kind? _____

Do you use an electric blanket? _____

List any allergies or sensitivities to drugs, supplements, herbs, foods, pollens, animals, or chemicals:

For the following illnesses, check the box if you have now or have had them, and include description, now vs. prior, treatment/action taken, and dates:

- ☐ Cancer _____
- ☐ AIDS/ HIV _____
- ☐ High Blood Pressure _____
- ☐ Elevated cholesterol _____
- ☐ Diabetes _____
- ☐ Heavy Metal Toxicity _____
- ☐ Major Dental Problems _____
- ☐ Rheumatoid Arthritis _____
- ☐ Lupus/ Auto-Immune illness _____
- ☐ Multiple Sclerosis _____
- ☐ Hepatitis/ Liver Disease _____
- ☐ Gall Stones _____
- ☐ Kidney Stones _____
- ☐ Low blood Pressure _____
- ☐ Hypoglycemia _____
- ☐ Candida _____
- ☐ Food/ Environmental Allergies _____
- ☐ Anemia _____
- ☐ Asthma _____
- ☐ Breast Cysts _____
- ☐ Osteoporosis _____
- ☐ Endometriosis _____
- ☐ Weight Disorder _____
- ☐ PMS _____
- ☐ Excessive Fatigue _____
- ☐ Miscarriage(s) _____
- ☐ Abdominal Pain _____
- ☐ Ovarian Cysts _____
- ☐ Gonorrhea/ Syphilis/ Chlamydia _____
- ☐ Fibroid _____
- ☐ Herpes _____
- ☐ Shingles _____
- ☐ Ulcerative Colitis/ Crohn's Disease _____
- ☐ Depression/ Nervous Breakdown _____
- ☐ Insomnia _____
- ☐ Attempted Suicide _____
- ☐ Mono/ EBV/ CMV _____
- ☐ Pneumonia _____
- ☐ Eczema/ Psoriasis _____
- ☐ Thyroid Disease _____

Additional Questions:

1) What % of your body's healing power do you feel you are using now?_____

2) How long do you think it will take for you to regain your health?

_____

3) What lifestyle/dietary changes do you think you need to make to feel better?

_____

4) What emotional or stress-related factors are of concern to you currently?

_____

5) What do you do to reduce stress in your life?

_____

6) How will your life be different when you regain your health?

_____

7) How can I help you reach a state of OPTIMAL HEALTH?

_____

Thank you for taking the time to complete this and for your thorough answers.

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Current Age
Approximate date of last menstrual period
Approximate date of last menstrual period at time when your periods were regular
Age of onset of menstruation (Menarche)
How long after Menarche did your periods get regular?
How many days did your menstrual flow last at that time?
What was cycle length when periods got regular at that time?
(number of days from the first day of menstrual flow of one cycle, to the first day of flow of the next)

Prior to the age of 18 or, your first pregnancy:
did you have "PMS" ___yes __no
did you have difficult periods ___yes __no
? breast tenderness: ___yes __no ? headaches: ___yes __no
__irritablility? __uterine cramps? __ heavy flow? __bloating?

Birth control methods: __Diaphragm __Condom __both __IUD [__# of years] __tubal ligation
Were you ever on the Birth Control Pill? ___yes __no __# of years or __# of months
If 'yes', how did you feel on it? ___better ___worse
did you gain weight while on it? _____yes _____no
Number of ...___miscarriages ___abortions

Have you ever been pregnant & given birth? __yes __no if yes, number of births ___
Your age at each pregnancy _____ _____ _____ _____
Number of months you breast fed this baby _____ _____ _____ _____
After the first 3 months was pregnancy
a very physically pleasant time for you? _____yes _____no
a worse time for you than non-pregnant? _____yes _____no
did you have diabetes during pregnancy? _____yes _____no
did you have nausea of pregnancy? _____yes _____no for how long?____

Have you had a recurrance or worsening of premenstrual symptoms after the age of 35: __yes __no
___PMS ___breast tenderness
After the age of 35, before menopause,
Is there a time of the month that you feel best? week: __1 __ 2: __ 3: __ 4
Is this the only time of the month you feel good? __yes __no

Breast size when younger or, prior to first pregnancy: __small __medium __large
Current breast size: __smaller than above __ larger than above

have you had any of the following:
__ breast cysts __breast biopsy __ breast cancer
have you had breast mammograms? if so, how many _____? any abnormal ____?
have you had breast ultrasounds? if so, how many _____? any abnormal ____?
have you had breast thermograms? if so, how many _____? any abnormal ____?
do you have breast implants (if so, when implanted_____?)
what percentage of time in a 24 hour day do you wear a bra? ____%

Have you had any of the following:

__uterine fibroids __D & C [__ # of] __ovarian cysts __endometriosis
__laparoscopic surgeries __cesarian sections __tubal ligation __endometrial biopsy
__hysterectomy: at what age__? __oopherectomy [removal of ovary(s)] ?__1 ?__2
__age of last pap smear __? abnormal pap smear [at what age__?]
__bone density tests _____ date of last one __normal __osteopenia __osteoporosis

Hormonal use: __Premarin __Provera __patch
__other hormones [list]_____
has any woman in your family had female cancer? __no __yes
if yes, who and what type? __breast __uterine __ovarian
who? _____ _____ _____ _____

Current Height ____feet ____inches
tallest height you ever were____feet ____inches
Weight age 25____lbs Weight now ____lbs
In your life have you had more muscle and hair than others? ____
more muscle than others with little body hair? ____?

Symptoms of estrogen deficiency:

__hot flashes __ warm rushes __temperature swings __night sweat
__kicking covers off at night __vaginal dryness __racing mind @ night
__trouble falling asleep __mental fogginess __depression
__headaches & migraines __intestinal bloating __diminished sexuality & sensuality
__weight gain __back & joint pain __heart palpitations

Symptoms of estrogen excess:

__breast tenderness [especially central] __breast swelling or enlarging
__water retention & swelling __impatient & snappy though with clear mind
__pelvic cramps __nausea

Symptoms of progesterone deficiency:

__difficulty sleeping __anxiety & nervousness __water retention
__no period __infrequent period __shorter cycle
__frequent & heavy periods __spotting before period __PMS
__cystic breasts __painful breasts __endometriosis __fibroids

Symptoms of testosterone deficiency:

__diminished sex drive __flabbiness
__diminished energy & stamina __diminished sense of security
__diminished coordination & balance __indecisiveness
__diminished armpit, pubic & body hair __hair loss
__diminished love of your body image __muscle weakness

1) What is your main complaint, and why, and how does it trouble you?

2) Do you have pain, and rate it on a scale of 1-10.

3) What do you expect this type of medicine, and particularly the diet changes, to do for you?

4) Were you breast fed, and for how long?

5) As a child, were you susceptible to infections

6) Have your tonsils or adenoids been removed? Or have you had an appendectomy?

7) As a child, did you have eczema, any other skin problems, or allergies?

8) Do you have mercury fillings or root canals?

9) Have you had alot of antibiotics?

10) What vaccinations have you received?

11) Are you following any particular diet?

12) Do you often feel very tired after a meal?

13) Do you often get attacks of intense hunger, so that you simply have to eat something?

14) Do you have regular bowel movements?

15) Are there any foods that you do not tolerate, or are especially fond of?

16) How much, and what, do you drink every day?

17) Do you sleep well? Do you snore?

18) What are you most afraid of?

19) What do you consider to be the cause of your problem?

20) Imagine that a wizard came along and could grant you one wish, but you can't request a wish for healing or to receive magical powers to change everything. What would you wish for?

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