New Patient Information

NAME: ____ SEX: ______ DOB: ___/___/___ AGE: ____
(Last) (First)

ADDRESS:_________________________________CITY:_______________STATE:_____ZIP:_____

HOME PHONE:(___)_______ CELL PHONE: (___)_______ WORK PHONE: (___)_______

EMAIL ADDRESS: ____________________________________ SSN:________________________
Would you like to receive our email newsletter? __Y __N

Additional Patient Information

Primary Care Physician: _________________________________Physician's Phone: (___)_______

Address: ___________________________City: _________________State: _______ Zip: ______

Employer: _________________________________Occupation:_______________________________
Marital Status(circle): Single Married Separated Divorced With Partner Widow(er)

Number of Children:_____________________Name of Spouse/Partner:______________________

Emergency Contact: ____________________Relationship to you: _______________

Emergency Contact #:(___)________________

Referral Information

How did you hear of us?____

Were you referred by a physician?: ___ Yes___ No

If "Yes", could you provide us with as much information as possible for the Referring

Physician?____

Referring Physician's Name:____

Address:____________________________City:_____________State:__________Zip:__________

Telephone Number: (___)__________

Charlotte, NC (980) 272-1897 Roanoke, VA (540) 585-1788

Dr. Dave Hamilton
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Patient Intake Form

Patient Name: ______________________ **DOB:** __________

List in order of importance what your health concerns are:

1) ______________________
2) ______________________
3) ______________________
4) ______________________
5) ______________________

Last time you had blood work done and with what physician: ______________________

____

Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type:						
High Blood Pressure:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness:	Y N	Y N	Y N	Y N	Y N	Y N
TB:	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease:	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus:	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis:	Y N	Y N	Y N	Y N	Y N	Y N

List all surgeries & hospitalizations, including date occurred:

1) ______________________ 4) ______________________
2) ______________________ 5) ______________________
3) ______________________ 6) ______________________

Please note when & why you have had each of the following:

X-Rays: ______________________ MRI/Cat Scans: ______________________
Ultrasounds: ______________________ Accidents: ______________________
TB Test: ______________________ Hepatitis C: ______________________
HIV: ______________________ Last Dental Visit: ______________________
Last Eye Exam: ______________________

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Patient Name: ______________________________ **DOB:** ______________

Did you have the following **D**isease (**D**), Get **I**mmunized (**I**), or **N**either (**N**):

Measles: D I N **Chicken Pox**: D I N **Mumps**: D I N **Rubella**: D I N
Tetanus: D I N **Whooping Cough**: D I N **Hemophilus (Hib)**: D I N **Hepatits B**: D I N
German Measles: D I N **Any vaccination reactions:** ______________________________

List **Y**es (**Y**), **N**o (**N**) or **P**ast (**P**) regarding use of the following:

Antacids: Y N P **Steroids**: Y N P **Smoking**: Y N P **Packs per day & number of years**: ______________
Analgesics: Y N P **Laxatives**: Y N P **Coffee**: Y N P **Cups per day if Yes/Past**: ______________
Soda Pop: Y N P **Ounces per day if Yes/Past**: ______________
Alcohol: Y N P **How often & how much if Yes/Past**: ________
Any Alcohol Addiction: Y N P **Any Alcohol Treatment**: Y N P
Recreational Drugs: Y N P **Any Drug Addictions**: Y N P
Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

____
____
____

List all known drug allergies and reaction you get when you take the medication:

____
____
____

Review of Systems:

Present Weight: ______________ **Weight one year ago**: ______________ **Height**: ______________
Maximum weight and when: ______________ **Minimum weight as adult & when**: ______________
Ideal Weight: ______________

REGARDING THE NEXT SECTION: Please circle (**Y)** if you have the problem **NOW**, (**N)** if you've **NEVER** had the problem, (**P)** if you had the problem in the **PAST**.

Good Energy: Y N P
Fatigue: Y N P
If you have fatigue, when in morning, afternoon, evening is it the worst? ______________________________
If you have fatigue, can you do what you need to during the day? Y N

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Patient Name: ______________________________ **DOB:** ______________

SKIN				
Rash:	Y N P		**Color Change:**	Y N P
Hives:	Y N P		**Lump:**	Y N P
Psoriasis/eczema:	Y N P		**Itchy:**	Y N P
Dry:	Y N P		**Warts/moles:**	Y N P
Cancer:	Y N P		**Perspiration:**	Y N P
HEAD				
Headache:	Y N P		**Migraine:**	Y N P
Dandruff:	Y N P		**Head Injury:**	Y N P
Oil/dry hair:	Y N P		**Hair loss:**	Y N P

NOSE				
Frequent Colds:	Y N P		**Nosebleeds:**	Y N P
Congestion:	Y N P		**Post Nasal Drip:**	Y N P
Polyps:	Y N P		**Seasonal Allergies:**	Y N P
EYES				
Dry/Watery:	Y N P		**Blurry Vision:**	Y N P
Double Vision	Y N P		**Cataracts:**	Y N P
Glaucoma:	Y N P		**Styes:**	Y N P
Strain:	Y N P		**Discharge:**	Y N P
Itchy:	Y N P		**Dark under Eyelid:**	Y N P
MOUTH/THROAT				
Canker sores:	Y N P		**Cold sores:**	Y N P
Sore Throat:	Y N P		**Gum disease:**	Y N P
Dentures:	Y N P		**Cavities:**	Y N P
Loss of taste:	Y N P		**Hoarseness:**	Y N P
NECK				
Stiffness:	Y N P		**Swollen Glands:**	Y N P
Full movement:	Y N P		**Tension:**	Y N P

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RESPIRATORY			
Cough:	Y N P	**TB:**	Y N P
Shortness of breath w/ exertion:	Y N P	**Bronchitis:**	Y N P
Shortness of breath sitting:	Y N P	**Pneumonia:**	Y N P
Shortness of breath lying down:	Y N P	**Asthma:**	Y N P
Wheezing:	Y N P	**Painful breathing:**	Y N P
CARDIOVASCULAR			
High Blood Pressure:	Y N P	**Rheumatic Fever:**	Y N P
Low Blood Pressure	Y N P	**Murmurs:**	Y N P
Arrhythmias:	Y N P	**Palpitations:**	Y N P
Edema:	Y N P	**Chest Pain:**	Y N P
URINARY TRACT			
Incontinence:	Y N P	**Pain w/ Urination**	Y N P
Frequent Infections:	Y N P	**Kidney Stones**	Y N P
Urgency:	Y N P	**Discharge/Blood:**	Y N P
GASTROINTESTINAL			
Heartburn:	Y N P	**Bowel Movement Freq:**	
Indigestion:	Y N P	**Recent BM Change:**	Y N P
Bloating:	Y N P	**Diarrhea/Constipation:**	Y N P
Nausea:	Y N P	**Hemorrhoids:**	Y N P
Vomiting:	Y N P	**Gall Bladder Disease**	Y N P
Change in Appetite:	Y N P	**Liver Disease:**	Y N P
Pancreatitis:	Y N P	**Ulcer**	Y N P
MALE HEALTH			
Testicular pain/swelling:	Y N P	**Sexually Active:**	Y N P
Hernia:	Y N P	**S.T.D.:**	Y N P
Discharge:	Y N P	**Prostate Disease/Symptoms:**	Y N P
Impotency:	Y N P	**Sexual Orientation:**	Hetero Homo Bi

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Patient Name: ______________________________ **DOB:** ____________

FEMALE HEALTH

Age Period Began:		**How Often Period Occurs:**	
How long period lasts:		**Heavy menstrual bleeding:**	Y N P
Menstrual cramping:	Y N P	**Menstrual Pain:**	Y N P
PMS:	Y N P	**Food cravings:**	Y N P
Times Pregnant:		**How many births:**	
Miscarriages:		**Abortions:**	
Last Pap Smear:		**Diagnosis:**	
Any abnormal paps:	Y N P	**When was abnormal:**	
Menopausal since what age:		**Use of hormones:**	Y N P
Type of hormones used:		**Healthy libido:**	Y N P
Dry vagina:	Y N P	**Sexually Active:**	Y N P
Pain w/ Intercourse:	Y N P	**Vaginitis:**	Y N P
S.T.D.:	Y N P	**Mammography:**	Y N P
Dexa Bone Scan:	Y N P	**If Yes, what were results:**	
Sexual Orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: ______________________________
____

MUSCULOSKELETAL

Weakness:	Y N P	**Arthritis:**	Y N P
Stiffness:	Y N P	**Leg Cramps:**	Y N P
Tremors:	Y N P	**Pain:**	Y N P

NERVOUS

Paralysis:	Y N P	**Sciatica:**	Y N P
Tingling/numbness:	Y N P	**Carpal tunnel syndrome:**	Y N P
Seizures:	Y N P	**Fainting:**	Y N P

MENTAL/EMOTIONAL

Depression:	Y N P	**Anger/irritability:**	Y N P
Suicidal:	Y N P	**High-strung/tense:**	Y N P
Anxiety:	Y N P	**Fear/Panic**	Y N P
Eating disorder:	Y N P	**Psych Hospitalization:**	Y N P

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Patient Name: ______________________ **DOB:** __________

Exercise

How often do you exercise? __________ **What type of exercise**? __________
For how long? __________ **Hobbies**: __________

Sleep

How long per night? __________ **If you wake up frequently, what is the reason**? __________
Nightmares: Y N P **Wake Refreshed**: Y N P **Must nap during the day**: Y N P
Sleep walk: Y N P **Grind teeth**: Y N P **Snore**: Y N P

Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? __________
Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? __________
Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? __________
Are you particularly sensitive to perfumes, gasoline or other vapors? __________
Do you use pesticides, herbicides or other chemicals around your home? __________

Social Life

Enjoy job: Y N P **Hours worked per week**: __________ **Highest Level of Education**: __________
Active spiritual practice: Y N P **Quality of significant relationship**: __________
History of sexual, mental/emotional, physical abuse: Y N P **If so, at what age and by whom**: __________
What is your greatest health concern: __________
How does it limit you the most: __________
How committed are you towards making valuable changes: Little Moderately Very

Typical Day's Diet

Breakfast: __________
Lunch: __________
Dinner: __________
Snacks: __________

Allergies

List all known Allergies (food, environment): __________