



### Consultation Intake Form

Date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Sex: M F

Address: \_\_\_\_\_

Phone: (day) \_\_\_\_\_ (evening) \_\_\_\_\_

e-mail: \_\_\_\_\_ Birth date: \_\_\_\_\_

What would you like help with at this time?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Present physical complaints: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Onset and length of symptoms: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

At or around the time of onset were other emotional stresses occurring? \_\_\_\_\_

\_\_\_\_\_

List any medications you are presently taking: \_\_\_\_\_

\_\_\_\_\_

List any Herbal Medicines, Supplements, Homeopathics, Over the Counter Medications you are presently taking: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

#### **PAST MEDICAL HISTORY**

Surgical History: \_\_\_\_\_

\_\_\_\_\_

Other Hospitalizations: \_\_\_\_\_

\_\_\_\_\_

Serious accidents, falls or injuries: \_\_\_\_\_

Any childhood accidents or physical traumas? \_\_\_\_\_

\_\_\_\_\_

Do You Have Any Allergies? \_\_\_\_\_ To What? \_\_\_\_\_

Present Weight: \_\_\_\_\_ One Year Ago: \_\_\_\_\_ 5 Years Ago: \_\_\_\_\_

### WOMEN'S HEALTH

**Do you experience any of the following, past or present? PLEASE CIRCLE**

Breast pain	Fibroids	Hot flashes
Irregular PAP	Vaginal dryness	Difficult menopause
Difficulty getting pregnant	Ovarian cysts	Pelvic pain
Endometriosis	Vaginal infection	Currently pregnant
STD's including HPV	Irregular menstrual cycles	

How many pregnancies? \_\_\_ Number of deliveries: \_\_\_ Vaginal \_\_\_ C-Section

Any complications? \_\_\_\_\_

Any problems post-partum \_\_\_\_\_

Have you had any miscarriages? \_\_\_ If so, when? \_\_\_\_\_

Have you had any abortions? \_\_\_ If so, when? \_\_\_\_\_

Method of contraception: \_\_\_\_\_

Do you have an IUD ? \_\_\_\_\_

Do you have any pain with intercourse? \_\_\_\_\_

Do you have difficulty achieving orgasm? \_\_\_\_\_

Do you have any problems with incontinence (difficulty holding your urine)? \_\_\_\_\_

Date of Last Menstrual Period? \_\_\_\_\_

### MENSTRUAL PATTERN (check all that apply):

Symptom	Yes	No	Explanation
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Painful Menstruation

Clots

Irregular Cycles

Dark Blood at Onset

Dark Blood at Conclusion

Heaviness in Lower Pelvis

Weak or Numb Legs

Other:

How many days do you bleed?

Light, medium or heavy flow?

Date of last pelvic exam?

Have you ever been told you have a tipped or tilted uterus?

### MENOPAUSE:

Have you entered Menopause yet? \_\_\_\_\_ If so, at what age? \_\_\_\_\_

Please check below if you have experienced any of the following:

Hot Flashes \_\_\_ Memory Loss \_\_\_ Depression \_\_\_

Insomnia \_\_\_ Mood Swings \_\_\_ Fatigue \_\_\_

Do any of the women on your mother's side of the family suffer from any of the following:

Infertility \_\_\_ Menstrual Problems \_\_\_ Difficult Menopause \_\_\_

Are you now, or have you ever taken: Birth Control Pills \_\_\_ Hormone Replacement Therapy? \_\_\_

### GENERAL

Do you have or have you had any of the following?

High Blood Pressure	___	Acne	___	Anorexia/Bulemia	___
Diabetes	___	Headaches	___	Heart Problems	___
Hepatitis	___	Skin Rashes	___	Kidney Problems	___
Cancer	___	Skin Fungus	___	Fainting Spells	___
Frequent Cold or Flu	___	Sinus Problem	___	Emotional Problems	___

**FAMILY HISTORY** (List any medical conditions, problems in family members)

### LIFESTYLE

Tobacco Use: Yes No How Much and How Often: \_\_\_\_\_

Alcohol Use: Yes No How Much and How Often: \_\_\_\_\_

Caffeine Use: Yes No How Much and How Often: \_\_\_\_\_

Other Drug Use: Yes No How Much and How Often: \_\_\_\_\_

How frequently do you exercise? Daily \_\_\_ Weekly \_\_\_ Rarely \_\_\_

Type of exercise: \_\_\_\_\_

### DIET

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

How many meals a week do you dine out? \_\_\_\_\_

How many times a week do you have:

Beef	___	White Rice	___	Soda Pop	___
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Pork	___	White Bread	___	Coffee	___
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Fish	___	Crackers	___	Black Tea	___
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Chicken	___	Chips	___	Milk	___
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Canned Foods	___	Ice Cream	___	Other Dairy	___
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Desserts	___				
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How many glasses of water do you drink daily? \_\_\_\_\_

What would you say is the worst thing that you do on your diet? \_\_\_\_\_

Are you subject to binge eating? \_\_\_ Of what foods? \_\_\_\_\_

What food do you find to be your weakness? \_\_\_\_\_

### DIGESTION

Appetite: good fair poor Explanation: \_\_\_\_\_

Digestion: good fair poor Explanation: \_\_\_\_\_

Do you experience Bloating or Gas after meals? \_\_\_ Sour burps or heartburn? \_\_\_

Do you feel Sleepy or Tired after meals? \_\_\_ How often? Daily /Weekly /Occasional

Are you on a Restricted Diet? \_\_\_ Explain: \_\_\_\_\_

## ELIMINATION

How often do you have a bowel movement? Daily \_\_\_ Times per Week Irregular \_\_\_

Do you ever have hard stools? \_\_\_ Do you ever have loose stools? \_\_\_

Urination: normal \_\_\_ scanty \_\_\_ more than 5 times daily \_\_\_ burning \_\_\_ strong odor \_\_\_ dark color \_\_\_

Any history of bladder or kidney infections? \_\_\_ If so, at what age? \_\_\_\_\_

## STRESS LEVEL

What would you rate your level of stress ( 0= no stress, 10 = maximum stress) \_\_\_\_\_

What are the major sources of stress in your life? \_\_\_\_\_

Who provides you support in your life? \_\_\_\_\_

How many hours of sleep do you get on an average night? \_\_\_\_\_

Do you usually wake up feeling tired \_\_\_ or rested \_\_\_?

Nerves: good \_\_\_ fair \_\_\_ poor \_\_\_

Anxiousness: often \_\_\_ sometimes \_\_\_ seldom \_\_\_

Depression: often \_\_\_ sometimes \_\_\_ seldom \_\_\_

Please explain your responses: \_\_\_\_\_

## EMOTIONAL AND SPIRITUAL

If romantically involved, how is your relationship? \_\_\_\_\_

Were there any emotional traumas in your early or present life? Please explain briefly.  
(ie. rape, great loss, suicide or death of a loved one, etc.) \_\_\_\_\_

If possible, please explain what you feel to be your most experienced negative emotion:

When do you most often feel this emotion? \_\_\_\_\_

Where are you, when you feel this negative emotion? \_\_\_\_\_

What is your opinion of yourself? \_\_\_\_\_

Have you ever been to counseling? \_\_\_ What was the outcome for you? \_\_\_\_\_

Do you meditate? \_\_\_ If so, how often? \_\_\_\_\_

Rate Yourself:    None            Some            Lots

Faith

Hope

Charity

Generosity

Humor

Fun

Is there an unrealized longing in your life? \_\_\_ What is it? \_\_\_\_\_

Briefly explain your relationship with each of your parents? \_\_\_\_\_

## WORK AND RECREATIONAL ACTIVITIES

Occupation: \_\_\_\_\_

Do you enjoy your work? \_\_\_\_\_

Are you involved with activities outside of work? \_\_\_\_\_

If so, what type of activities? \_\_\_\_\_

Do you have any hobbies or interests? \_\_\_\_\_

Do you have a satisfying love life? \_\_\_\_\_