Rasnow Integrative Wellness, Inc

New Patient Intake Questionnaire
Demographics

Name _____ Today's Date_____

Date of Birth _____ Place of Birth _____

Gender Identity_____ Gender Assigned at Birth_____

Mailing address _____

City_____ State_____ Zip_____ Ok to send mail? Y/N _____

Email: _____ Ok to email? Y/N _____

Phone Numbers: (please circle the preferred route of contact and hours you prefer to be called)

	Preferred?	Hours?
Home _____	❑	_____
Work _____	❑	_____
Cell _____	❑	_____

Insurance Information, If using:

Plan: _____ID # _____ Group #_____

Subscriber:_____ DOB if not self _____

Where did you previously receive or are currently receiving care?

PCP: _____ Last seen: _____ Phone #: _____

Specialists?_____

How did you hear about this practice? _____

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Current Health History

Please list your current health concerns in order of priority to you.
Indicate severity of symptoms using a scale of 1-10 with 10 being the worst you can imagine.

Symptoms/problem/diagnosis:	Severity now	Severity at its worst /(date)	Symptom onset (date)	What interventions have you tried so far?

Allergies or sensitivities to medications/supplements/food?

Drug/substance/food	Reaction:

Patient Name:

When was the last time you felt completely healthy?

_____

_____

What did that feel like?

_____

_____

How many hours of sleep do you get each night? _____
Do you sleep regular hours (ie go to bed and wake up at approximately the same time most days of the week? _____ Do you have trouble falling or staying asleep? _____
Do you use a CPAP machine or use medications/supplements to help you sleep?
_____

Do you drink caffeine? If so, how much? _____
Do you use tobacco or nicotine products?_____
Do you use cannabis or CBD/THC products? _____
Do you drink alcohol? If so, how much and often? _____

Do you follow a particular/specific diet? y/n _____
If so, how would you describe your diet generally:_____

What are your favorite foods?

_____
Do you eat regular meals from day to day? _____ Does your appetite vary? _____

How many days/week do you exercise? _____ What types do you enjoy? _____

Patient Name:

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Personal and Family Health History

Please indicate which of these conditions currently affect you or have affected you or your family members previously. Please provide details in the comments section.

Condition	Self, current	Self, past	Mother	Father	Grandparent	Aunt/Uncle	Sibling	Child	Comment
High Blood Pressure									
High Cholesterol									
Overweight/Obesity									
Diabetes									
Thyroid Problems									
Eczema/ Psoriasis/ chronic skin conditions									
Asthma/ COPD									
Seasonal allergies									
Food allergies									
Heart Attack/ Coronary Artery Disease/Stenting									
Genetic Disorder/ Chromosome Abnormality									
Breast/ ovarian/ uterine Cancer									
Lung Cancer									
Colon Cancer or Polyps									
Skin Cancer									
Migraines									
Other Chronic headache									
Multiple Sclerosis/ ALS/ Parkinson's disease									

Patient Name:

Condition	Self, current	Self, past	Mother	Father	Grandparent	Aunt/Uncle	Sibling	Child	Comment
Depression/ Anxiety									
Bipolar disorder/ Schizophrenia/ other									
Trauma/Exposure to Violence									
Constipation/Diarrhea/IBS									
Chron's/ Ulcerative Colitis									
Cataracts/Glaucoma/Vision Loss									
Vertigo/Dizziness									
Hearing Loss									
Blood disorder (sickle cell, thalassemia)									
Abnormal Uterine Bleeding/Fibroids									
Dementia/memory loss/Alzheimer's									
Stroke/ TIA									
Lupus/ Systemic Autoimmune disease									
Rheumatoid Arthritis, other inflammatory arthritis									
Addiction/ alcoholism									
Smoker (tobacco, marijuana)									
Miscarriage/ Pregnancy complications									
Infertility									
Kidney Disease/Dialysis									
Leg Ulcers or Amputations									

Patient Name:

Birth History:

Please describe what you know about your birth:
Were you born by cesarean section or vaginal delivery?

Were you born on time or prematurely?

Was your birth complicated in any way? Did you spend extra time in the hospital or in NICU?

Were your breastfed or bottle fed? If breastfed, do you know how long, or until what age?

Are you aware of any issues with colic or reflux as an infant? Rashes, allergies, or food sensitivities? Were you given any special diet as a result?

Childhood (the first 10 years):

Please describe the environment in which you spent the first 10 years of your life: For example, Did you live in the city or the country? Did you have pets as a child?

Do you remember being seriously ill or having frequent infections? Were you given antibiotics frequently?

Did you have any food aversions or frequent cravings then? Were you on any special diets?

How were your grades in school? Did you have any learning difficulties?

Did you have a healthy and secure relationship with your family or were there struggles? If you are open to describe these, please do so.

Patient Name:

Were you exposed to any of the following adverse childhood events? If you are comfortable describing, please do so- otherwise you can just indicate yes or no.

Exposure to/witnessing physical violence?

Ever a victim of physical violence?

Exposure to/witnessing frequent yelling, arguing or emotional battery?

Victim of sexual abuse?

Immediate family member with substance abuse/alcoholism?

Food or housing insecurity?

Other adverse event not listed above?

Adolescence (Age 10-20)

Do you remember any specific health changes that accompanied puberty such as acne, sleep problems, or significant mood changes?

What were some of your hobbies as a teenager?

Were there any significant changes or traumas that occurred in your life during this time period?

Any Significant Illnesses or changes to your health during this time period?

At what age did you become sexually active? _____
Was it a positive experience? y/n _____

For persons with a uterus:
At what age did you reach menarche (start your periods)? _____

Patient Name:

For each of the applicable decades of your life please reflect on any significant positive/negative life events and health events or struggles.

Age 20-30:
(Examples include any significant relationships, pregnancies, births, accidents, illnesses)

For persons who experienced pregnancies, how did you feel during and after your pregnancy(ies)?

Age 30-40
(examples include changes in body weight, development of new health struggles, new diagnoses, changes in job or activity level, injuries or major illnesses)

Age 40-50
(Examples include hormonal changes, changes in relationships, changes in sleep patterns, relocation to a different house or environment)

Please use additional sheets of paper or the back of this form to describe more significant health and personal events in either the decades listed above or those occurring later in life.

Patient Name:

Medications and Supplements Inventory

Medication or Supplement (include brand and dose)	Regimen for taking, including if taken only as needed or intermittently

Patient Name:

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4 Day Food and Activity Diary

Date: _____

TIME	Content/Description	Mood	Water?
Wake up :			
Breakfast:			
Snack:			
Lunch:			
Snack			
Dinner			
Bedtime:			
Activity:			

Date:_____

TIME	Content/Description	Mood	Water?
Wake up :			
Breakfast:			
Snack:			
Lunch:			
Snack			
Dinner			
Bedtime:			
Activity:			

Patient Name:

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Patient Name: