



Thank you for taking the time to visit our website. We ask that you complete the New Patient Intake forms legibly and as best you can, so we may better help you. If you come across an item you'd prefer not to answer, just go on to the next question.

Please have these forms completed prior to your arrival. We ask that you arrive at least 15 minutes prior to your scheduled appointment with completed forms so that we can put a chart together and go over a few more questions. We are a "fee for service" practice which means we ask for payment in full at time of service. We submit conventional lab work, so we ask that you bring your insurance card with you. As a courtesy, we can submit to your insurance for covered medical services for your convenience.

We are located just off the Loop 101 on Raintree Drive (exit #39). Go east to 92nd Street and turn left. We are at the Northeast corner of Raintree Drive and 92nd Street in the **Raintree Office Park** business complex.

We look forward to serving you and assisting you on your path to wellness.

9200 E. Raintree Dr. Ste 150, Scottsdale, AZ 85260
480 451-6161- Office /480 306-5304- Fax



New Patient Information

Today's Date: _____
Patient Name: _____ Age: _____ DOB: _____
Address: _____ City _____ State _____ Zip _____
Email: _____
Phone: (h) _____ (w) _____ (c) _____
Which is the best phone # for appointment reminders or messages? _____
Marital status: S / M / D / W Name of spouse or significant other: _____
children _____ at home _____ names: _____
Occupation: _____ Employer: _____
Employer address: _____ City _____ State _____ Zip _____
Insurance name and group #: _____
Primary Cardholder: _____

Your health care team:

Primary Care Physician: _____ City: _____
Other specialist and therapists (including MD, DC, Physical Therapist, Acupuncturist, ND, etc): _____

How did you hear about us (if referred, by whom): _____

Please list and describe your medical problems and health concerns in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Most recent lab testing and with what physician: _____

List all significant surgeries & hospitalizations with approximate dates:

- 1) _____
- 2) _____
- 3) _____
- 4) _____

Please describe most recent imaging and the reason, injury or concern:

X-Ray/mammogram _____

MRI/CT Scans: _____
Ultrasounds: _____ Bone density: _____

MUSCULOSKELETAL PROBLEMS

Please describe your pain or problem and its history with relevant details of injuries and treatments:

Problem#1: _____

_____ X-ray or
MRI? _____ Results: _____

Problem#2: _____

_____ X-ray or
MRI? _____ Results: _____

Problem#3: _____

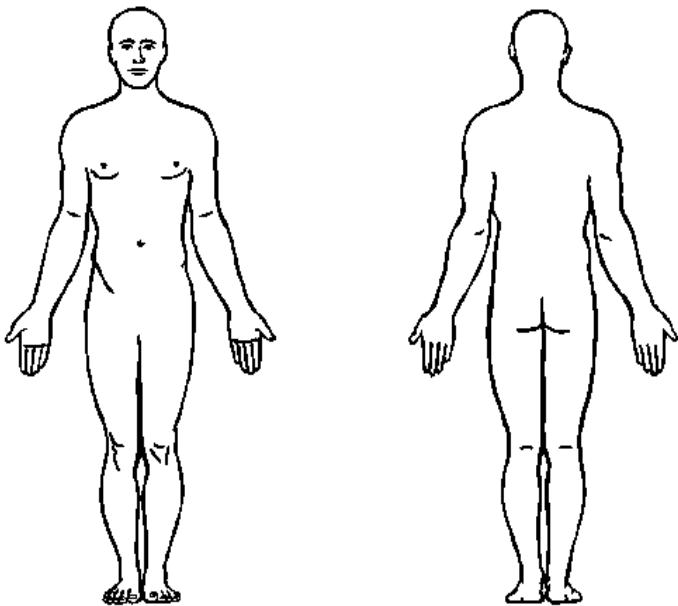
_____ X-ray or MRI? _____ Results: _____

Do you have any of the following?

Please mark: Y=Yes, current or recent problem; N=No, never a problem; P= Past problem, not current

Headache:	Y N P	Migraine	Y N P	Neck Pain:	Y N P
TMJ Pain:	Y N P	Upper Back Pain:	Y N P	Middle Back Pain:	Y N P
Low Back Pain:	Y N P	Hip Pain:	Y N P	Sciatica:	Y N P
Shoulder Pain:	Y N P	Elbow Pain:	Y N P	Wrist Pain:	Y N P
Thumb Pain:	Y N P	Finger pain	Y N P	Muscle Spasms	Y N P
Knee Pain:	Y N P	Ankle Pain:	Y N P	Foot Pain:	Y N P
Weakness:	Y N P	Stiffness:	Y N P	Numbness:	Y N P
Arthritis:	Y N P	Leg cramps:	Y N P	Tremors:	Y N P

Circle problem areas below:



OVERVIEW OF BODY SYSTEMS

For this section, please circle (Y) for CURRENTLY, (N) for NEVER and (P) for the PREVIOUSLY.

SKIN

Rash:	Y N P	Color Change:	Y N P	Acne:	Y N P
Hives:	Y N P	Itchy:	Y N P	Eczema:	Y N P
Psoriasis:	Y N P	Skin Cancer:	Y N P		

HEAD

Headaches:	Y N P	Headache Intensity: 1-10_____	H/A frequency:_____
Head Injury:	Y N P	Hair loss:	Y N P

NOSE

Frequent colds:	Y N P	Post nasal drip:	Y N P	Congestion:	Y N P
Seasonal allergies:	Y N P	Sinusitis:	Y N P	Nosebleeds:	Y N P

EYES

Dry eyes:	Y N P	Blurry/dbl vision:	Y N P	Glaucoma:	Y N P
Poor Night Vision:	Y N P	Double vision:	Y N P	Itchy:	Y N P

MOUTH/THROAT

Dental infections:	Y N P	Mercury fillings:	Y N P	Canker/Cold sore:	Y N P
Sore throats:	Y N P	Gum disease:	Y N P	Loss of taste:	Y N P

NECK

Pain:	Y N P	Tension:	Y N P	Stiffness:	Y N P
Swollen glands:	Y N P	Goiter:	Y N P	Immobility:	Y N P

RESPIRATORY

Cough:	Y N P	Bronchitis:	Y N P	Pneumonia:	Y N P
Short of breath:	Y N P	Asthma/wheezing:	Y N P	Emphysema:	Y N P
Valley Fever:	Y N P	Tuberculosis:	Y N P	COPD:	Y N P

CARDIOVASCULAR

High blood pressure:	Y N P	Arrhythmias:	Y N P	Chest pain:	Y N P
Heart attack/MI:	Y N P	Murmurs:	Y N P	Poor Circulation:	Y N P
Low blood pressure:	Y N P	Leg Swelling/Edema:	Y N P	Rheumatic fever:	Y N P

URINARY TRACT

Urgent need urinate:	Y N P	Incontinence:	Y N P	Frequent infections:	Y N P
Kidney stones:	Y N P	Pain w/urination:	Y N P	Discharge/blood:	Y N P

GASTROINTESTINAL

Heartburn/GERD: Y N P Bloating: Y N P Indigestion: Y N P
Constipation: Y N P Diarrhea/loose BM: Y N P Recent BM change: Y N P
Nausea: Y N P Vomiting: Y N P Change in appetite: Y N P
Hemorrhoids: Y N P Gall Bladder disease: Y N P Liver disease: Y N P

DIET & NUTRITION

3 Meals per day: Y N P Snack: Y N P Sit and enjoy: Y N P
Smoke: Y N P Caffeine: Y N P Alcohol: Y N P
Crave sugar: Y N P Crave salt: Y N P

ENERGY LEVEL

Energy level on scale 1-10 _____ When is energy lowest _____
Chronic Fatigue: Y N P Good Energy: Y N P

EXERCISE

Is weight a current concern: Y N Present Weight: _____ Height: _____
Lowest adult weight _____ What age _____ Maximum adult weight _____ What age _____
What type of exercise? Walk/Hike _____ Jog/Run _____ Bike _____ Golf _____ Yoga _____ Tennis _____
Other _____
Duration of exercise and how often? _____
Hobbies and/or other activities: _____

SLEEP PATTERNS

Insomnia: Y N P Wake refreshed: Y N P Nightmares: Y N P
Grind teeth: Y N P Nap during the day: Y N P Snore: Y N P
Do you wake up during the night: Y N P Why? _____
Bedtime: _____ Rise at _____ How many hours sleep to be refreshed? _____

MEN ONLY

Prostate disease: Y N P Nighttime urination: Y N P Hernia: Y N P
Testicular pain/swelling: Y N P Erectile Dysfunction: Y N P S.T.D.: Y N P
Discharge: Y N P Sexually active: Y N P

NERVOUS SYSTEM

Paralysis: Y N P Sciatica: Y N P
Fainting: Y N P Tingling/numbness: Y N P Seizures: Y N P

MENTAL/EMOTIONAL

Depression: Y N P Chronic Sadness: Y N P Anger/irritability: Y N P
Anxiety: Y N P High-strung/tense: Y N P Fear/Panic: Y N P
Suicidal: Y N P Eating disorder: Y N P Psych hospitalization: Y N P
Any alcohol addiction or treatment: Y N P Any drug addiction or treatment: Y N P

TOXIN EXPOSURE

Did you grow up near any polluted area or near any refinery? _____ What sort of pollutions were you exposed to _____

Do you now or have you had any jobs where you were exposed to solvents, chemicals, paints, heavy metals, fumes or other toxic materials? _____ If so, explain: _____

Are you sensitive to perfumes, dry cleaning, gasoline, solvents or other vapors? _____

Which types and what reactions? _____

Do you use a pest service, frequent dry cleaning, yard chemicals or other chemicals in or around your home _____

Describe: _____

SOCIAL LIFE

Enjoy job: Y N P Rate work stress 1-10 _____ Hours worked per week: _____

Active religious or spiritual practice: Y N P Prayer _____ Meditation _____ Affirmations _____

Quality of significant relationship: 1-10 _____

History of mental, emotional, sexual or physical abuse: Y N P Explain _____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparents	Spouse
Age if living	_____	_____	_____	_____	_____
Age at death	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____
Asthma/Allergies:	Y N	Y N	Y N	Y N	Y N
Autoimmune/SLE/RF:	Y N	Y N	Y N	Y N	Y N
Cancer:	Y N	Y N	Y N	Y N	Y N
Depression/Mental Dx:	Y N	Y N	Y N	Y N	Y N
Diabetes:	Y N	Y N	Y N	Y N	Y N
Domestic Violence:	Y N	Y N	Y N	Y N	Y N
High Blood Pressure :	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke:	Y N	Y N	Y N	Y N	Y N
Hepatitis/Mono:	Y N	Y N	Y N	Y N	Y N
High Cholesterol:	Y N	Y N	Y N	Y N	Y N
HIV/AIDS:	Y N	Y N	Y N	Y N	Y N
Inherited Birth Dx:	Y N	Y N	Y N	Y N	Y N
Kidney/Bladder Dx:	Y N	Y N	Y N	Y N	Y N
Liver/Gallbladder Dx:	Y N	Y N	Y N	Y N	Y N
Pneumonia:	Y N	Y N	Y N	Y N	Y N
Rheumatic Fever:	Y N	Y N	Y N	Y N	Y N
Thyroid Dx:	Y N	Y N	Y N	Y N	Y N

Circle if you have had the following Disease (D) Immunization (I) or Neither (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 Hepatitis: D I N HIV: D I N

Any reactions: _____

