



## New Horizons Integrative Medicine Initial Patient Intake Form

Date: \_\_\_\_\_ First Name: \_\_\_\_\_ Last Name: \_\_\_\_\_

Please tell us about each symptom on the following pages. If you have never had the symptom, please place a check mark in the Not Applicable column. If you have had the symptom in the past or are currently experiencing the symptom, please mark the appropriate choice in the Timing columns. Next, tell us how severe the symptom was or is currently, by placing a check in the mild, moderate or severe box. Last, indicate how frequently it occurred or is occurring now, by placing a check mark in the choice that best fits how often you experience the symptom.

| Symptom                              | Not Applicable<br>N/A | Timing |         | Severity |          |        | Frequency |            |       |
|--------------------------------------|-----------------------|--------|---------|----------|----------|--------|-----------|------------|-------|
|                                      |                       | Past   | Current | Mild     | Moderate | Severe | Rare      | Occasional | Often |
| Fatigue                              |                       |        |         |          |          |        |           |            |       |
| Fevers                               |                       |        |         |          |          |        |           |            |       |
| Weight Loss or Gain                  |                       |        |         |          |          |        |           |            |       |
| Hearing: Loss, Buzzing or Ringing    |                       |        |         |          |          |        |           |            |       |
| Ear Pain                             |                       |        |         |          |          |        |           |            |       |
| Dizziness, Vertigo                   |                       |        |         |          |          |        |           |            |       |
| Off Balance, Unsteady                |                       |        |         |          |          |        |           |            |       |
| Lightheadedness                      |                       |        |         |          |          |        |           |            |       |
| Sound Sensitivity                    |                       |        |         |          |          |        |           |            |       |
| Light Sensitivity                    |                       |        |         |          |          |        |           |            |       |
| Vision Loss, Double Vision, Floaters |                       |        |         |          |          |        |           |            |       |
| Eye Pain                             |                       |        |         |          |          |        |           |            |       |
| Head Congestion                      |                       |        |         |          |          |        |           |            |       |
| Sore Throat                          |                       |        |         |          |          |        |           |            |       |



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| Symptom                        | Not Applicable | Timing |      | Severity |      |          | Frequency |      |            |
|--------------------------------|----------------|--------|------|----------|------|----------|-----------|------|------------|
|                                |                | N/A    | Past | Current  | Mild | Moderate | Severe    | Rare | Occasional |
| Mouth Sores/Ulcers             |                |        |      |          |      |          |           |      |            |
| Dental Pain                    |                |        |      |          |      |          |           |      |            |
| Facial Paralysis, Bell's Palsy |                |        |      |          |      |          |           |      |            |
| Swollen Glands                 |                |        |      |          |      |          |           |      |            |
| Insomnia                       |                |        |      |          |      |          |           |      |            |
| Excessive Sleep, Night/Day     |                |        |      |          |      |          |           |      |            |
| Hair Loss                      |                |        |      |          |      |          |           |      |            |
| Cold Intolerance               |                |        |      |          |      |          |           |      |            |
| Heat Intolerance               |                |        |      |          |      |          |           |      |            |
| Night Sweats                   |                |        |      |          |      |          |           |      |            |
| Vivid Dreams                   |                |        |      |          |      |          |           |      |            |
| Nightmares                     |                |        |      |          |      |          |           |      |            |
| Constipation                   |                |        |      |          |      |          |           |      |            |
| Diarrhea                       |                |        |      |          |      |          |           |      |            |
| Nausea, Vomiting               |                |        |      |          |      |          |           |      |            |
| Stomach Pain, Heartburn        |                |        |      |          |      |          |           |      |            |
| Abdominal Pain, Cramping       |                |        |      |          |      |          |           |      |            |



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| Symptom                         | Not Applicable | Timing |      | Severity |      |          | Frequency |      |            |
|---------------------------------|----------------|--------|------|----------|------|----------|-----------|------|------------|
|                                 |                | N/A    | Past | Current  | Mild | Moderate | Severe    | Rare | Occasional |
| Blood in Stool                  |                |        |      |          |      |          |           |      |            |
| Chest Wall Pain, Sore Ribs      |                |        |      |          |      |          |           |      |            |
| Chest Pain, Heart Pain          |                |        |      |          |      |          |           |      |            |
| Heart Palpitations              |                |        |      |          |      |          |           |      |            |
| Heart Murmur                    |                |        |      |          |      |          |           |      |            |
| Heart Block on EKG              |                |        |      |          |      |          |           |      |            |
| Shortness of Breath             |                |        |      |          |      |          |           |      |            |
| Air Hunger, Breathlessness      |                |        |      |          |      |          |           |      |            |
| Chronic Cough                   |                |        |      |          |      |          |           |      |            |
| Joint Pain: Fingers, Toes       |                |        |      |          |      |          |           |      |            |
| Joint Pain: Ankles, Wrists      |                |        |      |          |      |          |           |      |            |
| Joint Pain: Knees, Elbows       |                |        |      |          |      |          |           |      |            |
| Joint Pain: Hips, Shoulders     |                |        |      |          |      |          |           |      |            |
| Joint Swelling: Fingers, Toes   |                |        |      |          |      |          |           |      |            |
| Joint Swelling: Ankles, Wrists  |                |        |      |          |      |          |           |      |            |
| Joint Swelling: Knees Elbows    |                |        |      |          |      |          |           |      |            |
| Joint Swelling: Hips, Shoulders |                |        |      |          |      |          |           |      |            |



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| Symptom                                | Not Applicable | Timing |      | Severity |      |          | Frequency |      |            |
|--|----------------|--------|------|----------|------|----------|-----------|------|------------|
|  |                | N/A    | Past | Current  | Mild | Moderate | Severe    | Rare | Occasional |
| Joint Stiffness                        |                |        |      |          |      |          |           |      |            |
| Back Pain                              |                |        |      |          |      |          |           |      |            |
| Neck Pain, Creaking Cracking           |                |        |      |          |      |          |           |      |            |
| Sore Soles of Feet                     |                |        |      |          |      |          |           |      |            |
| Muscle Pain                            |                |        |      |          |      |          |           |      |            |
| Muscle Weakness                        |                |        |      |          |      |          |           |      |            |
| Numbness, Tingling, Burning Sensations |                |        |      |          |      |          |           |      |            |
| Muscle Twitching, Jerking              |                |        |      |          |      |          |           |      |            |
| Muscle Cramping                        |                |        |      |          |      |          |           |      |            |
| Tremors                                |                |        |      |          |      |          |           |      |            |
| Seizures                               |                |        |      |          |      |          |           |      |            |
| Headaches                              |                |        |      |          |      |          |           |      |            |
| Confusion, Difficulty Thinking         |                |        |      |          |      |          |           |      |            |
| Word Search Difficultly, Name Block    |                |        |      |          |      |          |           |      |            |
| Poor Concentration, Attention          |                |        |      |          |      |          |           |      |            |
| Memory Loss, Forgetfulness             |                |        |      |          |      |          |           |      |            |
| Difficulty Reading, Absorbing New Info |                |        |      |          |      |          |           |      |            |



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| Symptom                                | Not Applicable | Timing |      | Severity |      |          | Frequency |      |            |
|--|----------------|--------|------|----------|------|----------|-----------|------|------------|
|  |                | N/A    | Past | Current  | Mild | Moderate | Severe    | Rare | Occasional |
| Disoriented, Getting Lost              |                |        |      |          |      |          |           |      |            |
| Speech Errors, Wrong Word, Misspeaking |                |        |      |          |      |          |           |      |            |
| Mood Swings                            |                |        |      |          |      |          |           |      |            |
| Depression                             |                |        |      |          |      |          |           |      |            |
| Anxiety, Panic                         |                |        |      |          |      |          |           |      |            |
| Irritability                           |                |        |      |          |      |          |           |      |            |
| Psychosis                              |                |        |      |          |      |          |           |      |            |
| Pain in the Genital Area               |                |        |      |          |      |          |           |      |            |
| Unexplained Menstrual Irregularity     |                |        |      |          |      |          |           |      |            |
| Breast Pain                            |                |        |      |          |      |          |           |      |            |
| Unexplained Milk Production            |                |        |      |          |      |          |           |      |            |
| Irritable Bladder                      |                |        |      |          |      |          |           |      |            |
| Bladder Pain                           |                |        |      |          |      |          |           |      |            |
| Bladder Dysfunction                    |                |        |      |          |      |          |           |      |            |
| Testicular Pain                        |                |        |      |          |      |          |           |      |            |
| Pelvic Pain                            |                |        |      |          |      |          |           |      |            |
| Erectile Dysfunction                   |                |        |      |          |      |          |           |      |            |



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|---------------------------------|----------------------------|----------------------------|--------------------------------|------------------------------|------|----------|-----------|------|------------|
|                                 |                            | N/A                        | Past                           | Current                      | Mild | Moderate | Severe    | Rare | Occasional |
| Loss of Libido                  |                            |                            |                                |                              |      |          |           |      |            |
| Anger Control Problems          |                            |                            |                                |                              |      |          |           |      |            |
| Trouble at School               |                            |                            |                                |                              |      |          |           |      |            |
| Behavioral Issues               |                            |                            |                                |                              |      |          |           |      |            |
| Trouble with Peers              |                            |                            |                                |                              |      |          |           |      |            |
| Symptoms Worse with Alcohol Use | Yes <input type="radio"/>  | No <input type="radio"/>   |                                |                              |      |          |           |      |            |
| Symptoms Flare Every Four Weeks | Yes <input type="radio"/>  | No <input type="radio"/>   |                                |                              |      |          |           |      |            |
| Degree of Disability            | None <input type="radio"/> | Mild <input type="radio"/> | Moderate <input type="radio"/> | Severe <input type="radio"/> |      |          |           |      |            |