Date_____ **MARGARET GENNARO, M.D.** **Adult Intake Form**

Patient's Name _____ **Email** _____
Last First Middle

Address _____
Street City State Zip

Home Phone ( ) _____ **Work Phone ( )**_____**Cell Phone ( )**_____

Date of Birth _____ **Marital Status** _____ **# of Children** _____ **Social Security #** _____

If patient is a minor, give parent's or guardian's name _____

Name of nearest relative not living with you _____

Address_____ **Phone** _____
Street City State Zip

How did you hear about our office? _____

Responsible Party Information – Patient is responsible for bill, your insurance may reimburse you.

Patient's Name _____
(or parent, if minor) Last First Middle

Address _____
Street City State Zip

Home Phone _____ **Work Phone** _____ **Email** _____

Birthdate_____ **Social Security #** _____ **Relationship to Patient** _____

Employer Name / Address _____

Spouse's Name _____
Last First Middle

Employer Name / Address _____

CONSENT

I understand that all responsibility for payment for services provided in this office for myself or my dependents is mine, due and payable at the time services are rendered unless other arrangements have been made. In the event payments are not received by the agreed upon dates, I understand that a 1- ½ % finance charge (18% APR) may be added to my account.

Patient Signature _____ **Date** _____

Parent or Responsible Party Signature _____ **Relationship** _____

INTAKE FORM FOR ADULT **NAME: _____**

Chief health complaint: (what is your main reason for coming in today? When did you notice your condition?) _____

_____

_____

_____

What kind of treatment have you received and from whom? _____

_____

_____

What have **you** done to relieve your condition? (Herbs, vitamins, diet, etc. Has it helped?) _____

_____

_____

Have you ever seen a naturopathic physician, chiropractor, acupuncturist, homeopath or other non-traditional health-care provider for your main complaint? [ ] No [ ] Yes

Or for any other problem? [ ] No [ ] Yes

What was the therapy and what were the results? _____

_____

What is the general state of your health? [ ] Excellent [ ] Good [ ] Average [ ] Fair [ ] Poor

On average, describe your energy level 1 – 10 (1= lowest & 10 = highest): _____

When during the day is your energy best? _____ Worst? _____

What is your current approximate weight? _____ Height? _____ Weight 1 year ago? _____

As an adult what has been your maximum _____ and minimum weight _____ (Not Pregnant)

Please list the 4 most significant, stressful events in your life, from the most recent to the most distant.

Are any of these continuing to impact your life? (circle: yes or no)

1. _____ Date:_____ Yes or No
2. _____ Date:_____ Yes or No
3. _____ Date:_____ Yes or No
4. _____ Date:_____ Yes or No

What childhood disease have you had? ____ measles ____ mumps ____ chickenpox
____ whooping cough ____ polio ____ diphtheria ____ rheumatic fever
____ scarlet fever ____ smallpox ____ typhoid fever ____ tuberculosis
____ mono, how long? _____

Please list all surgeries and hospitalizations including approximate dates. (Do not include normal deliveries.)

1. _____ Date:_____
2. _____ Date:_____
3. _____ Date:_____
4. _____ Date:_____
5. _____ Date:_____

_____ Check here if you have had more than 5 hospitalizations

_____ Check here if you have received a blood transfusion, when? _____

Which of the following have you had and indicate "now or past" & also when/how often.

____ pneumonia _____ ____ diabetes _____ ____ chronic infections _____
____ tonsillitis _____ ____ asthma _____ ____ migraines/headaches _____
____ eczema _____ ____ ear infection_____ ____ venereal disease _____
____ gonorrhea _____ ____ heart disease _____ ____ thyroid problems _____
____ syphilis _____ ____ herpes _____ ____ high blood pressure _____
____ allergies _____ ____ hepatitis _____ ____ manic/depression _____
____ seizures _____ ____ anemia _____ ____ weight problems _____
____ mono _____ ____ depression _____ ____ schizophrenia _____
____ stroke _____ ____ arthritis _____ ____ hypoglycemia _____
____ concussion _____ ____ other, list _____

Do you have any allergies to drugs, herbs, foods, animals or others? [ ] No [ ] Yes, what? _____

_____

Date of last menstrual period? _____ [ ] Normal [ ] Abnormal

How many "silver" fillings do you have? _____ How many root canals? _____

Test and Immunizations (check those you have had. Enter the year when last taken/given and results if known)

____ chest x-ray _____
____ kidney tests _____
____ G.I. series _____
____ colon x-ray _____
____ gallbladder test _____
____ E.K.G./E.C.G. _____
____ T.B. test _____
____ sigmoidoscopy _____
____ mammogram _____
____ pap smear _____
____ E.E.G. (brain wave test) _____
____ C.T. scan (of what?) _____
____ Thyroid blood tests _____
____ Rectal exam (<u>for men over 40</u>) _____ PSA (prostate blood test) _____
____ CBC/SMAC _____
____ Urinalysis _____
____ tetanus shot _____
____ polio series _____
____ flu shots _____
____ hepatitis shot _____
____ measles _____
____ mumps _____

Which of the following do you currently use? (amount, how often and how long)

____ alcohol _____ ____ tobacco _____
____ hormones _____ ____ coffee/tea _____
____ cortisone _____ ____ laxatives _____
____ sedatives _____ ____ antacids _____
____ pain killers _____ ____ diet pills _____

Other medications (give full name and dosage and how long have you been taking):

1. _____ Length:_____
2. _____ Length:_____
3. _____ Length:_____
4. _____ Length:_____
5. _____ Length:_____

Vitamins/herbs:

1. _____ Length:_____
2. _____ Length:_____
3. _____ Length:_____
4. _____ Length:_____
5. _____ Length:_____

Family History

Please list ages, health problems and if deceased, cause of death:

	Living (age?)	Health problems	Died (age?)	Cause
Your mother	_____	_____	_____	_____
Your father	_____	_____	_____	_____
Your brothers	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Your sisters	_____	_____	_____	_____
	_____	_____	_____	_____
	_____	_____	_____	_____
Mother's Mom	_____	_____	_____	_____
Mother's Dad	_____	_____	_____	_____
Father's Mom	_____	_____	_____	_____
Father's Dad	_____	_____	_____	_____

What is your nationality? (please list all background and give approximate %) _____
_____

Who do you currently live with? [ ] spouse [ ] partner [ ] parent(s) [ ] friends [ ] children [ ] alone

Are you? [ ] married [ ] divorced [ ] widowed [ ] single [ ] in a supportive relationship

What is your current level of education? _____ Are you satisfied with this? [ ] Yes [ ] No

Do you have children? [ ] No [ ] Yes, how many _____alive _____deceased

For women – how many? ____ miscarriages ____ abortions ____ stillbirths
Did you ever have? ____ toxemia ____ excessive nausea/vomiting

Do you have any blood relative (aunt, uncle, grandparent) who has had the following?

[ ] allergies [ ] arthritis [ ] asthma [ ] cancer [ ] diabetes [ ] anemia [ ] depression
[ ] skin disease [ ] heart attack [ ] high B. P. [ ] stroke [ ] sickle cell [ ] cataracts [ ] genetic problems
[ ] seizures [ ] ulcers [ ] venereal disease [ ] hypoglycemia [ ] schizophrenia
[ ] manic-depression [ ] other, _____

Occupation/household

How long have you lived at your present address? _____

Where have you lived previously? _____

Please describe location, if old or new place, i.e., new construction, damp or moldy. _____

_____

Do you have specialized air filtration at home? [ ] No [ ] Yes Do you live in a city? [ ] No [ ] Yes

Do you work in a building ? [ ] No [ ] Yes Do the windows open? [ ] No [ ] Yes

Do you have specialized air filtration at work? [ ] No [ ] Yes

Do you work in the presence of toxic fumes or chemical? [ ] No [ ] Yes, what _____

Do any of your hobbies involve toxic materials? [ ] No [ ] Yes

If you are a non-smoker, are you exposed to second hand smoke currently? [ ] No [ ] Yes In the past? [ ] No [ ] Yes

What do you use for your drinking water? [ ] bottled [ ] filtered [ ] tap water

Personal Habits

What do you enjoy the most in your life? _____

_____

What are your main interests or hobbies? _____

_____

What do you worry about most? _____

Do you currently exercise? [ ] No [ ] Yes, what kind, how much & how often? _____

_____

Do you have a spiritual affiliation or practice? [ ] No [ ] Yes, what? _____

How important is your spiritual life to you? (1 = not important 10 = very important) _____

Do you have problems falling or staying asleep? [ ] No [ ] Yes How many hours do you sleep a night? _____

How many times a week, on average, do you wake up refreshed? _____

Do you nap or rest horizontally during the day? [ ] No [ ] Yes, for how long? _____

If you work, do you enjoy your work? [ ] No [ ] Yes If no, explain _____

_____

Do you take vacations? [ ] No [ ] Yes

Do you meditate or do relaxation exercises regularly? [ ] No [ ] Yes, what _____

Have you traveled to many countries (for work, pleasure or military) Which? (give approximate dates) _____

_____

Diet: Is your diet primarily American food? [ ] No [ ] Yes If no, list anything unusual about your diet _____

_____

Please add anything else you feel is important:

Symptom Survey Form

INSTRUCTIONS: Number the boxes, which apply to you. Use **(1) for MILD** symptoms (occur once or twice a year), **(2) for MODERATE** symptoms (occur several times a year), and **(3) for SEVERE** symptoms (you are aware of it almost constantly).

Group One

1 [ ] Acid foods upset
2 [ ] Get chilled, often
3 [ ] "Lump" in throat
4 [ ] Dry mouth-eyes-nose
5 [ ] Pulse speeds after meal
6 [ ] Keyed up – fail to calm
7 [ ] Cuts heal slowly
8 [ ] Gag easily
9 [ ] Unable to relax; startles easily
10 [ ] Extremities cold, clammy
11 [ ] Strong light irritates
12 [ ] Urine amount reduced
13 [ ] Heart pounds after retiring
14 [ ] "Nervous" stomach
15 [ ] Appetite reduced
16 [ ] Cold sweats often
17 [ ] Fever easily raised
18 [ ] Neuralgia-like pains
19 [ ] Staring, blinks little
20 [ ] Sour stomach frequent

Group Two

21 [ ] Joint stiffness after arising
22 [ ] Muscle-leg-toe cramps at night
23 [ ] "Butterfly" stomach, cramps
24 [ ] Eyes or nose watery
25 [ ] Eyes blink often
26 [ ] Eyelids swollen, puffy
27 [ ] Indigestion soon after meals
28 [ ] Always seems hungry; feels "lightheaded" often
29 [ ] Digestion rapid
30 [ ] Vomiting frequent
31 [ ] Hoarseness frequent
32 [ ] Breathing irregular
33 [ ] Pulse slow; feels "irregular"
34 [ ] Gagging reflex slow
35 [ ] Difficulty swallowing
36 [ ] Constipation, diarrhea alternating
37 [ ] "slow starter"
38 [ ] Get "chilled" infreqeuntly
39 [ ] Perspire easily
40 [ ] Circulation poor, sensitive to cold
41 [ ] Subject to colds, asthma and bronchitis

Group Three

42 [ ] Eat when nervous
43 [ ] Excessive appetite
44 [ ] Hungry between meals
45 [ ] Irritable before meals
46 [ ] Get "shaky" if hungry
47 [ ] Fatigue, eating relieves
48 [ ] "Lightheaded" if meals are delayed
49 [ ] Heart palpitates if meals are missed or delayed
50 [ ] Afternoon headaches
51 [ ] Overeating sweets upsets
52 [ ] Awaken after few hours of sleep - hard to get back to sleep
53 [ ] Crave candy or coffee in the afternoons
54 [ ] Moods of depression – "blues" or melancholy
55 [ ] Abnormal craving for sweets or snacks

Group Four

56 [ ] Hands and feet go to sleep easily, numbness
57 [ ] Sigh frequently, "air hunger"
58 [ ] Aware of "breathing heavily"
59 [ ] High altitude discomfort
60 [ ] Opens windows in closed room
61 [ ] Susceptible to cold and fevers
62 [ ] Afternoon "yawner"
63 [ ] Get "drowsy" often
64 [ ] Swollen ankles worse at night
65 [ ] Muscle cramps, worse during exercise; get "charley horses"
66 [ ] Shortness of breath on exertion
67 [ ] Dull pain in chest or radiating into left arm, worse on exertion
68 [ ] Bruise easily, "black and blue" spots
69 [ ] Tendency to anemia
70 [ ] "Nose bleeds" frequent
71 [ ] Noises in head or "ringing in ears"
72 [ ] Tension under the breastbone, or feeling of "tightness", worse on exertion

Group Five

73 [ ] Dizziness
74 [ ] Dry skin
75 [ ] Burning feet
76 [ ] Blurred vision
77 [ ] Itching skin and feet
78 [ ] Excessive falling hair
79 [ ] Frequent skin rashes
80 [ ] Bitter, metallic taste in mouth in mornings
81 [ ] Bowel movements painful/difficult
82 [ ] Worries, feels insecure
83 [ ] Feeling queasy, headache over eyes
84 [ ] Greasy foods upset
85 [ ] Stools light-colored
86 [ ] Skin peels on foot soles
87 [ ] Pain between shoulder blades
88 [ ] Use laxatives
89 [ ] Stools alternate from soft to watery
90 [ ] History of gallbladders attacks of gallstones
91 [ ] Sneezing attacks
92 [ ] Dreaming, nightmare type - bad dreams
93 [ ] Bad breath (halitosis)
94 [ ] Milk products cause distress
95 [ ] Sensitive to hot weather
96 [ ] Burning or itching anus
97 [ ] Crave sweets

Group Six

98 [ ] Loss of taste for meat
99 [ ] Lower bowel gas several hours after eating
100 [ ] Burning stomach sensations, eating relieves
101 [ ] Coated tongue
102 [ ] Pass large amounts of foul-smelling gas
103 [ ] Indigestion ½ - 1 hour after eating; may be up to 3 – 4 hours
104 [ ] Mucous colitis or irritable bowel
105 [ ] Gas shortly after eating
106 [ ] Stomach "bloating" after eating

Group Five

(A)

107 [ ] Insomnia
108 [ ] Nervousness
109 [ ] Can't gain weight
110 [ ] Intolerance to heat
111 [ ] Highly emotional
112 [ ] Flush easily
113 [ ] Night sweats
114 [ ] Thin, moist skin
115 [ ] Inward trembling
116 [ ] Heart palpitations
117 [ ] Increased appetite without weight gain
118 [ ] Pulse fast at rest
119 [ ] Eyelids and face twitch
120 [ ] Irritable and restless
121 [ ] Can't work under pressure

(B)

122 [ ] Increase in weight
123 [ ] Decrease in appetite
124 [ ] Fatigue easily
125 [ ] Ringing in ears
126 [ ] Sleepy during the day
127 [ ] Sensitive to cold
128 [ ] Dry or scaly skin
129 [ ] Constipation
130 [ ] Mental sluggishness
131 [ ] Hair coarse, falls out
132 [ ] Headaches upon arising wear off during the day
133 [ ] Slow pulse
134 [ ] Frequency in urination
135 [ ] Impaired hearing

(C)

137 [ ] Failing memory
138 [ ] Low blood pressure
139 [ ] Increased sex drive
140 [ ] Headaches, "splitting or rending" type
141 [ ] Decreased sugar tolerance

(D)

142 [ ] Abnormal thirst
143 [ ] Bloating of abdomen
144 [ ] Weight gain around hips or waist
145 [ ] Sex drive reduced or lacking
146 [ ] Tendency to ulcers, colitis
147 [ ] Increased sugar tolerance
148 [ ] Women: menstrual disorders
149 [ ] Young girls: lack of menstrual function

(E)

150 [ ] Dizziness
151 [ ] Headaches
152 [ ] Hot flashes
153 [ ] Increased blood pressure
154 [ ] Hair growth on face or on body (female)
155 [ ] Sugar in urine (not diabetes)
156 [ ] Masculine tendencies (female)

(F)

157 [ ] Weakness, dizziness
158 [ ] Chronic fatigue
159 [ ] Low blood pressure
160 [ ] Nails weak, ridged
161 [ ] Tendency to get hives
162 [ ] Arthritic tendencies
163 [ ] Perspiration increase
164 [ ] Bowel disorders
165 [ ] Poor circulation
166 [ ] Swollen ankles
167 [ ] Crave salt
168 [ ] Brown spots or bronzing of skin
169 [ ] Allergies – tendency to asthma
170 [ ] Weakness after colds, influenza
171 [ ] Exhaustion - muscular and nervous
172 [ ] Respiratory disorders

Female Only		**Male Only**
173 [ ] Very easily fatigued	.	186 [ ] Prostate trouble
174 [ ] Premenstrual tension	.	187 [ ] Urination difficult or dribbling
175 [ ] Painful menses	.	188 [ ] Night urination frequent
176 [ ] Depressed feelings before menstruation	.	189 [ ] Depression
177 [ ] Menstruation excessive and prolonged	.	190 [ ] Pain on inside of legs or heels
178 [ ] Painful breasts	.	191 [ ] Feeling of incomplete bowel evacuation
179 [ ] Menstruate too frequently	.	192 [ ] Lack of energy
180 [ ] Vaginal discharge	.	193 [ ] Migrating aches and pains
181 [ ] Hysterectomy/ovaries removed	.	194 [ ] Tire too easily
182 [ ] Menopausal hot flashes	.	195 [ ] Avoids activity
183 [ ] Menses scanty or missed	.	196 [ ] Leg nervousness at night
184 [ ] Acne, worse at menses	.	197 [ ] Diminished sex drive
185 [ ] Depression of long standing	.	

Important

TO THE PATIENT: Please list below the five main physical complaints you have in order of their importance:

1. _____
2. _____
3. _____
4. _____
5. _____

I certify the information on this form is correct to the best of my knowledge. I will not hold Dr. Gennaro or any members of her staff responsible for nay errors or omissions that I may have made.

_____ _____

Patient or Guardian Signature Date

_____ _____

Reviewed by Date