New Patient Intake Form

Thank you for your interest pursuing health at the Riordan Clinic. As 'Co-learners' you will work with the doctors and staff to understand your whole health picture; therefore, we ask for a significant history prior to our initial visit. Thank you for taking the time to thoughtfully complete this form. We look forward to discussing your personal health history from this holistic/detective perspective (looking for root causes.) See you at our first visit!

Thank you,

The Riordan Clinic Team

Name: ______________________ Date: ____________

Address: ______________________ Age: ________

City: ____________ State: ______ Zip Code: Gender: M❑ F ❑

Telephone # (home): ____________ (work): ____________ (Cell): ____________

Email Address: ______________________ Date of Birth: ____________

Education: ______________________

Marital Status: Married ❑ Separated ❑ Divorced ❑ Widowed ❑ Single ❑ # Children ______

Live with: Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone: ❑

Occupation: ____________ Hours per week: ____________ Retired: ❑

Employer: ____________ Work Address: ____________

How did you hear about The Riordan Clinic and/or who can we thank for referring you?

____

Emergency Contact: Relationship: ____________

Address: ______________________ Phone: ____________

What are your most important health problems? List in order of importance.

1. ______________________
2. ______________________
3. ______________________
4. ______________________
5. ______________________

The following questions will help us understand your expectations.

1. Why did you choose to come to The Riordan Clinic?

___

___

2. What aspect of holistic / nutritional approach appeals to you?

___

___

3. As the process of assessment, planning, intervention, and follow-up progresses, how will you know you are better? What will you be able to do that you can't do now?

___

___

4. What is your present level of commitment to address any underlying causes of your health concerns that relate to your lifestyle? (Rate 1-10 = 100% committed)

   1 2 3 4 5 6 7 8 9 10

5. What lifestyle habits do you currently engage in that you believe support your health?

___

___

6. What lifestyle habits do you currently engage in that you believe harm your health?

___

___

7. What beliefs/obstacles do you foresee that could undermine your progress?

___

___

8. What else is important to you that we (the Riordan Clinic doctors and staff) should be aware of as we begin working together with you as co-learners?

___

___

___

Cancer History

Primary Cancer		Secondary Cancer (ie. Metastasis)	
Onset Date		Onset Date	
Location		Location	
Initial Stage		Stage	
Current Stage			

Previous Treatments (ie. Surgery, Chemo, Radiation)			
Type			
Started			
Ended			

Previous Treatments (ie. Surgery, Chemo, Radiation)			
Type			
Started			

Family History

	Father	Mother	Siblings	Maternal Grandparents	Paternal Grandparents	Spouse	Children
Age if living:							
Age when Died:							
Reason for Death:							
If Cancer, type:							

If present, mark an "X"							
Thyroid Disorder							
High Blood Pressure							
Heart Attach							
Asthma / Allergies							
Mental Illness							
Autoimmune							
Diabetes							
Osteoporosis							
Other							

Doctor, Hospitalization, Surgery, Imaging

Primary Care Physician (name and phone #) ______________________________

Please Note when and why you have had each of the following:

X-Rays: ____________________ MRI/CT Scans: ____________________

Ultrasounds: ____________________ EKG: ____________________

Last Dental Visit: ____________________ Last Eye Exam: ____________________

Surgery: ______________________________

Allergies

Are you hypersensitive to:

Any drugs? ______________________________

Any foods? ______________________________

Any substances in the environment or chemicals? ______________________________

Have you ever had allergy testing? ______________________________

(If yes, indicate when and details) ______________________________

Current Medications/Supplements

Please list **any** prescription, over the counter medications, or vitamins/supplements you are taking and dosages:

Prescription Medications	**OTC Medications** (ibuprofen, antacids, sleep aids, laxatives, etc.)	**Vitamins/Supplements**
1. ____________	1. ____________	1. ____________
2. ____________	2. ____________	2. ____________
3. ____________	3. ____________	3. ____________
4. ____________	4. ____________	4. ____________
5. ____________	5. ____________	5. ____________
6. ____________	6. ____________	6. ____________
7. ____________	7. ____________	7. ____________
8. ____________	8. ____________	8. ____________
9. ____________	9. ____________	9 ____________
10. ____________	10. ____________	10. ____________

Health Assessment

General Information

(Y) = Yes (N) = No (P) = in the Past

Current Height: ______________ Weight: __________ Weight 1 Year Ago: ______________

Maximum Weight: ___________ When: __________ Ideal Weight: ____________________

Do you have sufficient energy throughout the day? Y N

Please rate your energy from 1-10 (best)? 1 2 3 4 5 6 7 8 9 10

When is your energy best? ______________________________

When is your energy worst? ______________________________

Habits/Lifestyle

(Y) = Yes (N) = No (P) = in the Past

Main interests and hobbies: ______________________________

Do you exercise? Y N

If yes, what kind/how often ______________________________

Hours of sleep each night	__________	Enjoy your work?	Y N
Sleep well?	Y N	Take vacations?	Y N
Awake rested?	Y N	Spend time outside?	Y N
Have a supportive relationship?	Y N	How many hours of TV per day?	__________
Have a history of abuse?	Y N	How much time/day in relaxation?	__________
Been treated for drug dependence?	Y N	Do you eat 3 meals a day?	Y N
Use Alcoholic beverages?	Y N	Do you go on diets often?	Y N
Treated for alcoholism?	Y N P	Do you eat out often?	Y N
Do you use tobacco?	Y N P	Do you drink coffee?	Y N P
How many years and packs/day?	__________	Do you drink soda/pop?	Y N
Have a religious/spiritual practice?	Y N P	If yes, quantity per day or week	__________

REVIEW OF SYSTEMS

(Y) = Yes (N) = No (P) = in the Past

Mental / Emotional

Treated for emotional problems	Y N P	Depression	Y N P
Mood Swings	Y N P	Anxiety or nervousness	Y N P
Considered/Attempted suicide	Y N P	Tension	Y N P
Poor concentration	Y N P	Memory problems	Y N P

Immune

Reactions to immunizations	Y N P	Chronic infections	Y N P
Chronic Fatigue	Y N P	Slow wound healing	Y N P
Chronically swollen glands	Y N P		

Endocrine (Hormone System)

Underactive thyroid	Y N P	Heat or cold intolerance	Y N P
Low blood sugars	Y N P	Excessive hunger	Y N P
Excessive thirst	Y N P	Seasonal depression	Y N P
Fatigue	Y N P		
Night Sweats	Y N P		

Neurologic

Seizures	Y N P	Paralysis	Y N P
Muscle weakness	Y N P	Numbness or tingling	Y N P
Loss of memory	Y N P	Loss of balance	Y N P
Vertigo or dizziness	Y N P	Motion Sickness	Y N P

Skin

Rashes	Y N P	Eczema/Hives	Y N P
Acne	Y N P	Itching	Y N P
Color changes	Y N P	Hair loss	Y N P
Lumps	Y N P	Brittle	Y N P
Dry skin	Y N P		

Head/Neck

Headaches	Y N P	Jaw/TMJ problems	Y N P
Migraines	Y N P	Lumps	Y N P
Head injury	Y N P	Swollen glands	Y N P

Eyes

Spots in Eyes	Y N P	Cataracts	Y N P
Impaired vision	Y N P	Glasses/contacts	Y N P
Blurriness	Y N P	Eye pain/strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P
Double vision	Y N P	Glaucoma	Y N P

Ears

Impaired hearing	Y N P	Ringing in the ears	Y N P
Earaches	Y N P	Dizziness	Y N P

Nose and Sinuses

Frequent colds	Y N P	Nose Bleeds	Y N P
Stuffiness	Y N P	Hay fever/Post Nasal Drip	Y N P
Sinus problems		Loss of smell	Y N P

Mouth and Throat

Frequent sore throat	Y N P	Copious saliva	Y N P
Teeth grinding	Y N P	Sore tongue/lips	Y N P
Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P		

Respiratory

Cough	Y N P	Pain on breathing	Y N P
Spitting up blood	Y N P	Shortness of breath	Y N P
Asthma	Y N P	Shortness of breath lying down	Y N P
Pneumonia	Y N P	Bronchitis	Y N P
Emphysema	Y N P		

Cardiovascular

Heart disease	Y N P	Swelling in ankles	Y N P
High Blood pressure	Y N P	Chest pain	Y N P
Blood clots	Y N P	Murmurs	Y N P
Phlebitis	Y N P	Fainting	Y N P
Rheumatic fever	Y N P	Palpitations	Y N P

Gastrointestinal

Trouble swallowing	Y N P	Heart burn/reflux	Y N P
Change in thirst	Y N P	Abdominal pain/cramps	Y N P
Change in appetite	Y N P	Belching or passing gas	Y N P
Nausea/vomiting	Y N P	Constipation	Y N P
Ulcer	Y N P	Diarrhea	Y N P
Yellow skin	Y N P	Bowel Movements per day	
Gall bladder disease	Y N P	Black stools	Y N P
Liver disease	Y N P	Blood in stool	Y N P
Hemorrhoids	Y N P		

Urinary

Pain on urination	Y N P	Increased frequency	Y N P
Frequency at night	Y N P	Inability to hold urine stream	Y N P
Frequent infections	Y N P	Kidney stones	Y N P

Musculoskeletal

Joint pain or stiffness	Y N P	Arthritis	Y N P
Broken bones	Y N P	Weakness	Y N P
Muscle spasms/ cramps/ pain	Y N P	Sciatica	Y N P
Osteoporosis / Osteopenia	Y N P		

Blood Vessels

Easy bleeding or bruising	Y N P	Anemia	Y N P
Deep leg pain	Y N P	Cold hands/feet	Y N P
Varicose veins	Y N P		

Male Reproductive

Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Discharge or sores	Y N P
Are you sexually active	Y N P	Sexually transmitted disease	Y N P
Impotence	Y N P	If yes, which one(s): ______________	
Testicular masses	Y N P	______________________________	

Female Reproductive/Breasts

Age of first menses	________	Birth Control	Y N P
Age of last menses (if menopausal)	______	What type: ______________________	
Length of cycle (days)	________	Number of pregnancies	______________
Duration of menses (days)	________	Number of live births	______________
Are cycles regular	Y N P	Number of miscarriages	______________
Bleeding between cycles	Y N P	Number of abortions	______________
Painful menses	Y N P	Endometriosis	Y N P
Heavy or excessive flow	Y N P	Ovarian cysts	Y N P
PMS	Y N P	Breast lumps	Y N P
If yes, what are your symptoms ______		Nipple discharge	Y N P
____________________________		Last pap smear	______________
____________________________		Last mammogram	______________
Pain during intercourse	Y N P	Have you had a bone density scan	Y N