BRIEF INTAKE FORM

Thank you for your interest in pursuing IVC Now at the Riordan Clinic. As "Co-learners" you will work with the providers and staff to understand your whole health picture; therefore, we ask for a significant history prior to your initial visit. Thank you for taking the time to thoroughly complete this form. - *Thank you, Riordan Clinic Team*

PATIENT INFORMATION	**TODAY'S DATE**	☐ *Male* ☐ *Female* *(at birth)*
	Preferred Pronouns: ☐ she/her ☐ he/him ☐ they/them *(please check)*	

Full Legal Name	*Preferred Name*	*Date of Birth*

Street Address	*Apartment/Suite*

City	*State/Province*	*Postal/Zip Code*

Country	*Telephone Number*	*Mobile Number*

Email Address (as you want used for communications with the Riordan Clinic and for your Patient Portal access, see p. 35 for details.)

Marital Status	*Number of Children*
☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single	

Live with

☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone ☐ Other _____

Occupation	*Hours per week*	*Retired*
		☐

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

EMERGENCY CONTACT	
Name	*Relationship*
Address	*Phone*

PHARMACY INFORMATION	
Pharmacy Name	*Phone*
Pharmacy Address	

ALLERGIES AND SENSITIVITIES

Please list **any** known allergies or sensitivities and label as such. If none, please mark the section with N/A.

Drug/Prescription(s)	*Food(s)*
Substances in the environment/chemicals	
If you have had allergy testing, when and where was the test(s) performed? Please provide as many details as you can.	

CURRENT MEDICATIONS/SUPPLEMENTS

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

PLEASE BRING A COMPLETE DETAILED LIST, INCLUDING DOSAGES, WITH YOU TO YOUR FIRST APPOINTMENT.

Prescription Medications	**Over the Counter Medications** *(Ibuprofen, antacids, sleep aids, laxatives, etc.)*	**Vitamins/Supplements**

HEALTH ASSESSMENT

GENERAL INFORMATION

Current height	*Current weight*	*Weight one year ago*
Lifetime maximum weight	*When were you at your max weight?*	*Your ideal weight*

Do you have sufficient energy throughout the day?	☐ Yes ☐ No	*Please rate your energy from 1-10 (10 being best)*
		Low Energy < 1 2 3 4 5 6 7 8 9 10 > High Energy

When is your energy best?	*When is your energy worst?*

HABITS/LIFESTYLE *(Y) = Yes (N) = No (P) = in the Past*

Do you drink alcoholic beverages?	☐ Y ☐ N ☐ P	*Do you sleep well?*	☐ Y ☐ N
Have you been treated for alcoholism?	☐ Y ☐ N ☐ P	*Do you wake rested?*	☐ Y ☐ N
Have you been treated for drug dependence?	☐ Y ☐ N ☐ P	*How many hours of sleep per night?*	
For any of the above, please explain:		*How much time per day in relaxation?*	
Do you use tobacco?	☐ Y ☐ N ☐ P	*Do you enjoy your work?*	☐ Y ☐ N
How many years and packs/day?		*Do you take vacations?*	☐ Y ☐ N
Do you drink coffee?	☐ Y ☐ N	*Do you have a religious or spiritual practice?*	☐ Y ☐ N
If yes to coffee, quantity per day?		*Do you have a supportive relationship?*	☐ Y ☐ N
Do you drink soda/pop?	☐ Y ☐ N ☐ P	*Main interests and hobbies:*	
If yes to soda, quantity per day?		*Do you exercise?*	☐ Y ☐ N
Do you eat three meals a day?	☐ Y ☐ N	If yes, what kind and how often?	
Do you go on diets often?	☐ Y ☐ N ☐ P	*Do you spend time outside?*	☐ Y ☐ N
Do you eat out often?	☐ Y ☐ N	*How many hours of TV per day?*	

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	☐ Y ☐ N ☐ P	Loss of smell	☐ Y ☐ N ☐ P

REVIEW OF SYSTEMS *(Y) = Yes (N) = No (P) = in the Past*			
MOUTH AND THROAT			
Frequent sore throat	☐ Y ☐ N ☐ P	Excessive/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	Black stools	☐ Y ☐ N ☐ P
Gall bladder disease	☐ Y ☐ N ☐ P	Blood in stool	☐ Y ☐ N ☐ P
Liver disease	☐ Y ☐ N ☐ P		
Hemorrhoids	☐ Y ☐ N ☐ P	Bowel movements per day: _____	
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		
PAIN			
Are you experiencing consistent pain?	☐ Y ☐ N ☐ P	How severe is the pain? *(scale of 1-10)*	
If yes, where?		How long have you been having this pain?	

REVIEW OF SYSTEMS *(Y) = Yes (N) = No (P) = in the Past*

MALE REPRODUCTIVE

Hernias	☐ Y ☐ N ☐ P	Discharge or sores	☐ Y ☐ N ☐ P
Testicular pain	☐ Y ☐ N ☐ P	Sexually transmitted disease	☐ Y ☐ N ☐ P
Are you sexually active?	☐ Y ☐ N ☐ P	If yes, which sexually transmitted diseases have you been diagnosed with and when?	
Impotence	☐ Y ☐ N ☐ P		
Testicular mass(es)	☐ Y ☐ N ☐ P		
Prostate disease	☐ Y ☐ N ☐ P		

FEMALE REPRODUCTIVE/BREASTS

Are you sexually active?	☐ Y ☐ N ☐ P	Sexually transmitted disease	☐ Y ☐ N ☐ P
Discharge or sores	☐ Y ☐ N ☐ P	If yes, which sexually transmitted diseases have you been diagnosed with and when?	

Age of first menstrual cycle	*Age of last menstrual cycle (if menopausal)*
Length of cycle (days)	*Duration of menstrual cycle (days)*

Are cycles regular?	☐ Y ☐ N ☐ P	Heavy or excessive flow	☐ Y ☐ N ☐ P
Painful menstruation	☐ Y ☐ N ☐ P	Bleeding between cycles	☐ Y ☐ N ☐ P
Pain during intercourse	☐ Y ☐ N ☐ P	Breast lumps	☐ Y ☐ N ☐ P
Endometriosis	☐ Y ☐ N ☐ P	Nipple discharge	☐ Y ☐ N ☐ P
Ovarian cysts	☐ Y ☐ N ☐ P	PMS	☐ Y ☐ N ☐ P

Birth Control	*What type?*	If yes to PMS, what are your symptoms?
☐ Y ☐ N ☐ P		

Number of pregnancies	*Number of live births*	*Number of miscarriages*	*Number of abortions*

Last pap smear	*Last mammogram*

Have you had a bone density scan?	☐ Y ☐ N ☐ P	*Results:*
Have you had a thermography scan?	☐ Y ☐ N ☐ P	*Results:*