PROCARE
Nutrition • Functional Medicine

Intake Form

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General Information

Date _____

Name _____
First *Middle* *Last*

Preferred Name _____

Date of Birth _____ Age: _____ Gender: ◯ Male ◯ Female
(dd/mm/yyyy)

Primary Address _____
Number,Street *Apt #*

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

Genetic Background ◯ African ◯ Asian ◯ Caucasian
◯ European ◯ Hispanic ◯ Native America
◯ Other: _____

Highest Education Level ◯ High School ◯ Under-Graduate ◯ Post Graduate

Job Title _____ Hours per week _____

Nature of Business _____

Marital Status ◯ Single ◯ Married ◯ Divorce ◯ Widowed ◯ Partnership

Home Phone _____ Work Phone _____ Cell phone _____

Email _____

Emergency Contact _____
Name *Phone Number*

Primary Care Physician _____
Phone Number

How did you hear about our office? _____

Story Page

Name: _____ Date: _____

Please tell us your story about your health in the space below.

Medical Questionnaire

Allergies

to Medication/Supplement/Food	Reaction

Complaints/Concerns

What do you hope to achieve by working with us?

If you could permanently eliminate three problems, what would they be?

1. _____
2. _____
3. _____

When was the last time you felt well? _____

Did something trigger the change in your health/symptoms? _____

What makes you feelworse? _____

What makes you feelbetter? _____

What health care providers (including alternative practitioners) have you seen for these conditions? _____

Have you had any specialized testing or preventative tests performed? _____

Previous injuries? _____

Previous surgeries or hospitalizations? _____

Medical History

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy)*

Past	Ongoing	GASTROINTESTINAL
		Irritable Bowel Syndrome
		Inflammatory Bowel Disease
		Crohn's
		Ulcerative Colitis
		Gastritis or Peptic Ulcer Disease
		GERD(reflux)
		Celiac Disease
		Gallstones
		Other:

Past	Ongoing	CANCER
		Lung Cancer
		Breast Cancer
		Colon Cancer
		Ovarian Cancer
		Prostate Cancer
		Skin Cancer
		Other:

Past	Ongoing	CARDIOVASCULAR
		Anemia
		Heart attack
		Heart disease
		Stroke
		Elevated cholesterol
		Arrhythmia (irregular heartbeat)
		Hypertension (high blood pressure)
		Rheumatic fever
		Mitral Valve Prolapse
		Other:

Past	Ongoing	GENITAL & URINARY SYSTEMS
		Kidney stones
		Gout
		Interstitial Cystitis
		Frequent urinary tract infections
		Frequent yeast infections
		Erectile dysfunction or sexual dysfunction

Past	Ongoing	MUSCULOSKELETAL / PAIN
		Osteoarthritis
		Fibromyalgia
		Chronic Pain
		Other:

Past	Ongoing	INFLAMMATORY or AUTOIMMUNE
		Chronic Fatigue Syndrome
		Grave's Disease
		Hashimoto's Disease
		Immune Deficiency Disease
		Lupus SLE
		Multiple Sclerosis
		Rheumatoid Arthritis
		Sjogren's Disease
		Other Autoimmune Disease
		Name:
		Poor Immune Function (frequent infections)
		Severe Infectious Disease

Past	Ongoing	METABOLIC / ENDOCRINE
		Diabetes Type I or Type II
		Metabolic Syndrome
		Hypoglycemia
		Insulin Resistance or Pre-Diabetes
		Hypothyroidism (low thyroid)
		Hyperthyroidism (overactive thyroid)
		Endocrine problems
		Weight fluctuations
		Other:

Past	Ongoing	MISCELLANEOUS
		Chicken Pox / Shingles
		Hepatitis
		Herpes
		Measles / Mumps
		Mononucleosis
		Other Infectious Disease
		Name:

Medical History *(continued)*

Diseases/Diagnosis/Conditions *Check appropriate box and provide date of onset (mm/yyyy).*

Past	Ongoing	RESPIRATORY DISEASE
		Asthma
		Chronic Sinusitis
		Bronchitis
		Emphysema
		Pneumonia
		Tuberculosis
		Sleep Apnea
		Other

Past	Ongoing	SKIN DISEASE
		Eczema
		Psoriasis
		Acne
		Melanoma
		Skin Cancer
		Other:

Past	Ongoing	NEUROLOGIC / MOOD
		Depression
		Anxiety
		Bipolar Disorder
		Schizophrenia
		Headaches
		Migraines
		ADD/ADHD
		Autism
		Mild Cognitive Impairment
		Memory Problems
		Parkinson's Disease
		ALS
		Seizures
		Alzheimer's
		Other:

Gynecologic History *(For Women Only)*

OBSTETRIC HISTORY *(Check Box If Yes and Provide Number of Occurrences)*

☐	Pregnancies	☐	Post-Partum Depression
☐	Caesarean	☐	Toxemia
☐	Vaginal Deliveries	☐	Gestational Diabetes
☐	Miscarriage	☐	Baby Over 8 pounds
☐	Abortion	☐	Currently Breast Feeding
☐	Living Children (ages)	☐	Hysterectomy Full or Partial

MENSTRUAL HISTORY *(Check Box If Yes)*

Last period?_____ Frequency? _____ Length? _____ Pain? Yes No

Heavy periods? Yes No Clotting? Yes No Ever skipped a period? Yes No

Do you use contraception? Type & for how long _____

WOMEN'S DISORDERS/ HORMONAL IMBALANCES

☐	Fibrocystic Breasts	☐	Mood Swings
☐	Lumps in Breasts	☐	Decreased Libido
☐	Breast Soreness	☐	Loss of Urine Control
☐	Breast Cancer	☐	Concentration/Memory Problems
☐	Endometriosis	☐	Non-period Bleeding
☐	Fibroids	☐	Vaginal Dryness
☐	Infertility	☐	Vaginal Discharge
☐	Hot Flashes	☐	PCOS

Breast tenderness, water retention, irritability or PMS symptoms in the 2nd half of your cycle? Yes or No

Last Mammogram _____ PAP _____ Bone Density _____ Breast Biopsy _____

Are you in Menopause? Yes or No Age at Menopause _____

Are you on Hormone Replacement Therapy? Type _____ How Long? _____

Medications

CURRENT MEDICATIONS

Medication	Dose	Frequency	Start Date *(month/year)*	Reason for Use

PREVIOUS MEDICATIONS
(LAST 10 YEARS)

Medication	Dose	Frequency	Start Date *(month/year)*	Reason for Use

NUTRITIONAL SUPPLEMENTS
(VITAMINS / MINERALS / HERBS)

Supplement & Brand	Dose	Frequency	Start Date *(month / year)*	Reason for Use

Have you had prolonged or regular use of Tylenol? Yes No

Have you had prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin? Yes No

Have you had regular use of acid blocking drugs (Tagamet, Zantac, Prilosec, etc.)? Yes No

Antibiotics more than 3 times / year or long-term antibiotics? Yes No

Use of steroids (Prednisone, nasal allergy inhalers) in the past? Yes No

Family Health History (Please indicate current and past history to the best of your knowledge)

	Father	Mother	Brother	Sister	Children	Maternal Grandmother	Maternal Grandfather	Paternal Grandfather	Paternal Grandmother
Age (if still living)									
Age at death (if deceased)									
ADD/ADHD									
ALS or other Motor Neuron Diseases									
Alzheimer's									
Arthritis									
Asthma									
Autoimmune Diseases (such as Lupus)									
Bladder disease									
Blood clotting problems									
Cancer (any)									
Celiac disease									
Dementia									
Depression									
Diabetes									
Eczema									
Emphysema									
Environmental Sensitivities									
Epilepsy									
Genetic Disorders									
Headache									
Heart Disease									
High Blood Pressure									
High Cholesterol									
Inflammatory Arthritis (Rheumatoid, Psoriatic, Ankylosing spondylitis)									
Irritable Bowel Syndrome									
Kidney disease									
Mental Disorders									
Multiple Sclerosis									
Obesity									
Osteoporosis									
Smoking or Other Addiction									
Stroke									
Ulcers									

Review of Systems

Past	Ongoing	GENERAL
		Fever
		Chills / Cold all over
		Aches / Pains
		General weakness
		Difficulty sweating
		Excessive sweating
		Swollen glands
		Cold hands & feet
		Fatigue
		Difficulty falling asleep
		Sleepwalker
		Nightmares
		No dream recall
		Early waking
		Daytime sleepiness
		Distorted vision

Past	Ongoing	EARS
		Aches
		Discharge
		Pains
		Ringing
		Deafness / Hearing loss
		Itching
		Pressure
		Hearing aid
		Frequent infections
		Tubes in ears
		Sensitive to loud noises

Past	Ongoing	JOINT / MUSCLE
		Pain wakes you
		Arm / leg weakness
		Balance problems
		Muscle cramping
		Muscle stiffness in AM
		Weather bothers you
		Restless Leg Syndrome

Past	Ongoing	HEAD
		Poor concentration
		Confusion
		Headaches:
		After meals
		If meals skipped
		Severe
		Migraine
		Frontal
		Occipital
		Afternoon
		Daytime
		Concussion / Whiplash
		Mental sluggishness
		Forgetfulness
		Indecisive
		Face twitch
		Poor memory
		Head injury

Past	Ongoing	EYES
		Feeling of sand
		Double vision
		Blurred vision
		Poor night vision
		Seeing bright flashes
		Halo around lights
		Eye pains
		Dark circles under eyes
		Strong light irritates
		Cataracts
		Floaters in eyes
		Visual hallucinations
		Conjunctivitis

Past	Ongoing	Neck
		Stiffness
		Swelling
		Lumps
		Neck glands swell

Past	Ongoing	SKIN
		Cuts heal slowly
		Bruise easily
		Rashes
		Pigmentation
		Changing moles
		Calluses
		Eczema
		Psoriasis
		Dryness / cracking skin
		Oiliness
		Itching
		Acne
		Hives
		Fungus on nails
		Peeling skin
		Nails split
		White spots on nails
		Crawling sensation
		Burning on bottom of feet
		Athletes foot
		Cellulite
		Is your skin sensitive to
		Sun
		Fabrics
		Detergents
		Lotions / Creams

Past	Ongoing	THROAT
		Mucus
		Difficulty swallowing
		Frequent hoarseness
		Tonsillitis
		Enlarged glands
		Need to clear throat
		Throat closes up

Review of Systems *(continued)*

Past	Ongoing	GASTROINTESTINAL
		Peptic / Duodenal ulcer
		Poor appetite
		Excessive appetite
		Gallstones
		Gallbladder pain
		Nervous stomach
		Feel full after small meal
		Indigestion
		Heartburn
		Acid reflux
		Hiatal hernia
		Nausea
		Vomiting
		Vomiting blood
		Abdominal pain/cramps
		Gas
		Diarrhea
		Constipation
		Bowel changes
		Rectal bleeding
		Tarry stools
		Rectal itching
		Use laxatives
		Bloating
		Belch frequently
		Anal fissures
		Bloody stools

Past	Ongoing	MOUTH
		Coated tongue
		Sore tongue
		Dental problems
		Bleeding gums
		Canker sores
		TMJ
		Cracked lips / corners
		Fever blisters
		Wear dentures
		Grinding teeth
		Bad breath
		Dry mouth
		Metallic taste
		Dental fillings – amalgam
		Root canal
		Implants

Past	Ongoing	CIRCULATION / RESPIRATION
		Extremities cold/clammy
		Hands / Feet go to sleep
		High blood pressure
		Chest pain
		Pain between shoulders
		Dizziness upon standing
		Fainting spells
		High cholesterol
		High triglycerides
		Wheezing
		Irregular heartbeat
		Palpitations
		Low exercise tolerance
		Frequent coughs
		Breathing heavily
		Frequently sighing
		Shortness of breath
		Night sweats
		Varicose veins / spider veins
		Mitral valve prolapse
		Murmurs
		Skipped heartbeat
		Heart enlargement
		Angina pain
		Bronchitis / Pneumonia
		Emphysema
		Croup
		Frequent colds
		Heavy / tight chest
		Prior heart attack?
		When____/____/____
		Phlebitis
		Swollen ankles

Past	Ongoing	EMOTIONAL
		Convulsions
		Dizziness
		Fainting spells
		Blackouts / Amnesia
		Frequently jittery
		Startled by noises
		Anxiety/Feeling of panic
		Forgetful
		Listless / groggy
		Withdrawn feeling
		Nervous breakdown
		Unable to focus
		Tends to worry
		Considered a nervous person
		Unusual tension
		Frustration
		Emotional numbness
		Break out in cold sweat
		Profuse sweating
		Depressed
		Frightening dreams
		Had psychiatric care
		Use tranquilizers
		Misunderstood by others
		Irritable
		Feeling of hostility
		Hyperactive
		Workaholic

Review of Systems *(continued)*

Past	Ongoing	KIDNEY / URINARY
		Burning
		Frequent urination
		Blood in urine
		Night time urination
		Problem passing urine
		Kidney pain
		Kidney stones
		Painful urination
		Bladder infections
		Kidney infections
		Bedwetting
		Trichomonas

Past	Ongoing	NOSE / SINUSES
		Stuffy
		Bleeding
		Running / Discharge
		Infected
		Polyps
		No smell
		Symptoms change with the seasons

Past	Ongoing	MEN'S HISTORY *For Men Only*
		Prostate enlargement
		Prostate infection
		Change in libido
		Impotence
		Lump in testicles
		Sore on penis
		Genital pain
		Hernia
		Prostate cancer
		Difficulty obtaining erection
		Difficulty maintaining erection
		Urination at night
		How many?
		Urine urgency
		Urine hesitancy
		Loss of control
		PSA test
		Result:

Pain

Are you currently in pain? Yes No If yes, is the source of your pain due to an injury? Yes No

If yes, please describe and the date the injury occurred. _____

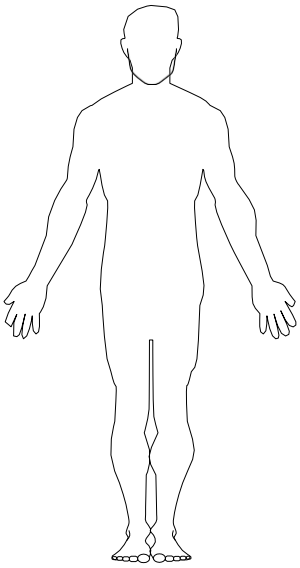
_____

If no, please describe how long you have experienced this pain and what you believe it is attributed to.

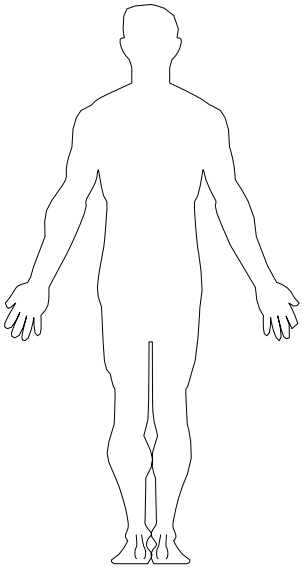
_____

Please use the illustrations below to describe the severity of your pain.

A= ache B= burning N= numbness S= stiffness T=tingling Z= sharp/shooting



Front



Back

Left

Right

Social History

Height (feet/inches)	Current Weight
Usual Weight +/-5lbs.	Desired Weight +/- 5lbs.
Highest Adult Weight	Lowest Adult Weight

Do you grocery shop? Yes No Do you cook? Yes No Do you read food labels? Yes No

If no, who does? _____

Do you avoid any particular foods? Yes No

If yes, types and reason _____

How many meals do you eat out per week? ◯ 0-1 ◯ 2-3 ◯ 4-5 ◯ 6 or more

How many alcoholic beverages per week? ◯ 0-1 ◯ 2-3 ◯ 4-5 ◯ 6 or more

Do you smoke? Yes No How many years? _____ Attempts to quit? _____

Do you use recreational drugs? Yes No Type: _____

Do you exercise? Yes No Type & frequency: _____

Nutritional History

Check all the factors that apply to your current lifestyle and eating habits

	Erratic eating pattern		Love to eat
	Fast eater		Eat because I have to
	Late night eating		Have a negative relationship with food
	Dislike healthy food		Struggle with eating issues
	Travel frequently		Emotional eater (sad, lonely, stressed, etc.)
	Non-availability of healthy foods		Confused by nutrition advice
	Reliance on convenience		Family has special dietary needs or preferences
	Poor snack choices		Time constraints

The most important thing I should change about my eating to improve my health is:

_____

My usual breakfast consists of:

_____

My usual lunch consists of:

_____

My usual dinner consists of:

_____

My usual snacks are:

_____

Do you currently follow a special diet or nutritional program? If yes explain:

_____

I mostly like to eat:

_____

I do not like to eat:

_____

DO YOU FEEL **WORSE** WHEN YOU EAT:		DO YOU FEEL **BETTER** WHEN YOU EAT:	
High fat foods		High fat foods	
High carbohydrate foods (breads, pasta, potatoes)		High carbohydrate foods (breads, pasta, potatoes)	
Refined sugar or junk food		Refined sugar or junk food	
Fried foods		Fried foods	
1 or 2 alcoholic drinks		1 or 2 alcoholic drinks	
Other:		Other:	

Digestive History

Foreign travel? Yes No Where? _____ Wilderness camping? Yes No Where? _____

Do you feel you digest your food well? Yes No Do you feel bloated after meals? Yes No

Frequency of bowel movements? _____ Consistency?

_____

Color? _____ Odor? _____Gas? _____

Stress/Coping

Ever been to counseling? Yes No

Do you feel you have a high amount of stress in your life? Yes No Do you feel you handle it well? Yes No

Daily Stressors: Rate on scale 1-10. (1 - minimal stress. 10 - very high stress)

Work____ Family____ Social____ Finances____ Health____ Other__

What do you do to relax? _____

Average number of hours you sleep? _____ Usually bedtime? _____ Wake up? _____

Do you have trouble falling asleep? Yes No Staying asleep? Yes No

Environmental & Detoxification Assessment

Do you have known environmental allergies or chemical sensitivities? Describe: _____

_____

Do you have a known history of exposure to any harmful chemicals? Explain: _____

_____

Do you dry clean your clothes frequently? Yes No Have you been exposed to mold? Yes No

What brands of personal care products do you use? (deodorant, lotion, soap, etc.) _____

_____

Readiness Assessment *Rate on a scale of: 5 (very willing) to 1 (not willing)*

In order to improve your health, how willing are you to:	5	4	3	2	1
Significantly modify your diet	◯	◯	◯	◯	◯
Take nutritional supplements each day	◯	◯	◯	◯	◯
Keep a record of everything you eat each day	◯	◯	◯	◯	◯
Modify your lifestyle (e.g. work demands, sleep habits)	◯	◯	◯	◯	◯
Practice relaxation techniques	◯	◯	◯	◯	◯
Engage in regular exercise	◯	◯	◯	◯	◯
Have periodic lab tests to assess progress	◯	◯	◯	◯	◯

Thank you for taking the time to complete this health history questionnaire. The information derived from these forms will provide valuable data in identifying the underlying problems of your health concerns rather than simply treating the symptoms. We look forward to helping you on your road to lifelong health!

Sincerely,

Dr. Scotting and the ProCare Team