



## Dr. Julie Nyquist Intake Form

3. When did this situation or concern begin? \_\_\_\_\_

4. Have you done anything about this situation or concern or gotten any advice or treatment for it? \_\_\_Yes \_\_\_No

- If yes, please describe below:

Modality	Past	Currently	Helpful?
Chiropractic			
MD/OB/Midwife			
Acupuncture			
Physical Therapy			
Naturopath			
Massage Therapy			
Counselor			

Circle or add other modalities you have utilized:

Yoga   Pilates   Chi Gong   Essential Oils   Homeopathy   O.T./P.T.   Osteopath   CranioSacral Therapy

5. Please circle which aspects of your life are affected by this health concern:

Work	Recreation/play	Rest/sleep
Social life	Walking	Sitting
Exercise	Eating	Love life

Comments \_\_\_\_\_  
\_\_\_\_\_

6. Have any other family members had the same or similar concerns? \_\_\_ Yes \_\_\_ No

7. Is there any time when you don't feel this condition or it is not on your mind? \_\_\_ Yes \_\_\_ No

- If yes, when? \_\_\_\_\_

8. Is there any time of day or activity that makes you more aware of it? \_\_\_ Yes \_\_\_ No

- If yes, when? \_\_\_\_\_

9. Why do you think this has happened or continues to happen? \_\_\_\_\_

- Do you think this is the sole cause? \_\_\_ Yes \_\_\_ No

- If no, what else is involved? \_\_\_\_\_

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**Part II – Stress Survey:** Please grade the following stresses in order of increasing intensity:

**0 - no awareness of any stress**  
**2 - moderately stressful**

**1 - slightly stressful**  
**3 - extremely stressful**

1. **Overall Physical Stress, Trauma:** Includes: surgeries, difficult birth, falls, accidents, injuries, postural stress, physical abuse, repetitive work stressors (sitting, typing, lifting, bending, etc.). 0 1 2 3
2. **Overall Emotional/Mental Stress:** Includes: loss of loved ones, rapid change in life situation, mental, emotional or sexual abuse, relationship concerns, job concerns, legal concerns, financial concerns, move of home/school, separation/divorce, stress of being ill or caretaker for someone who is ill. 0 1 2 3
3. **Overall Chemical Stress:** Includes: drugs, medications, fumes, processed foods, fast food, smoke/second-hand smoke, sodas, environmental toxins. 0 1 2 3

Comments: \_\_\_\_\_

4. Do you belong to a Health Club or have a home exercise routine? \_\_Yes \_\_No. If yes, describe: \_\_\_\_\_
5. In general, what types of foods do you eat? \_\_\_\_\_
6. Do you have a meditation, prayer, or other spiritual practice? \_\_\_\_Yes \_\_\_\_No  
\_\_\_\_\_
7. When stressed, how do you "center yourself" or "re-group"?  
\_\_\_\_\_
8. What aspects of your life please you, bring you joy, or help you to feel better about yourself?  
\_\_\_\_\_

**Part III – Health and Healing History:**

1. Review of Systems:

**ALLERGY/IMMUNOLOGY**

Autoimmune Disease	Y	N
Drug Allergies	Y	N
Food Allergies	Y	N
Seasonal Allergies	Y	N
Other _____		

**CARDIOVASCULAR**

Chest Pain	Y	N
High Blood Pressure	Y	N
Leg Cramping	Y	N
Palpitations	Y	N
Swelling of feet, ankles, hands	Y	N
Varicose veins	Y	N
Other _____		

**EAR/NOSE/THROAT/MOUTH**

Ear Infection	Y	N
Hearing Loss	Y	N
Ringing in ears/tinnitus	Y	N
Sinus Problems	Y	N
Snoring	Y	N
Sore Throat	Y	N
Thrush	Y	N
Other _____		

**ENDOCRINE**

Diabetes	Y	N
Excessive Thirst	Y	N
Fatigue	Y	N
Glandular or hormone problem	Y	N
Thyroid problems	Y	N
Too hot/cold	Y	N
Other _____		

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**EYES**

Blurred vision/double vision	Y	N
Migraine auras	Y	N
Wear glasses/contact lenses	Y	N
Other _____		

**GASTROINTESTINAL**

Abdominal pain	Y	N
Constipation	Y	N
Diarrhea	Y	N
Heartburn/GERD	Y	N
Loss of appetite	Y	N
Nausea/vomiting	Y	N
Stomach pain	Y	N
Ulcer	Y	N
Other _____		

**HEMATOLOGIC/LYMPHATIC**

Anemic	Y	N
Lymphedema	Y	N
Swollen glands	Y	N
Other _____		

**MIND/STRESS**

Anxiety	Y	N
Depression	Y	N
Memory loss or confusion	Y	N
Sleep problems	Y	N
Other _____		

**MUSCULOSKELETAL**

Arthritis	Y	N
Broken bones	Y	N
Fibromyalgia	Y	N
Joint stiffness or swelling	Y	N
Weakness of muscles/joints	Y	N
Other _____		

**NEUROLOGICAL**

Convulsions or seizures	Y	N
Dizzy/lightheaded	Y	N
Frequent or recurrent headaches	Y	N
Vertigo	Y	N
Other _____		

**RESPIRATORY**

Asthma or wheezing	Y	N
Frequent cough	Y	N
Short of breath	Y	N
Sinus issues	Y	N
Other _____		

**SKIN**

Change in appearance of mole	Y	N
Change in hair or nails	Y	N
Skin rash or itching	Y	N
Other _____		

**URINARY**

Incontinence	Y	N
Kidney stones	Y	N
Painful urination	Y	N
Urinate often	Y	N
Other _____		

**WOMEN ONLY:**

Breast Feeding	Y	N
Breast Pain	Y	N
Breast Lump	Y	N
Fertility Issues	Y	N
Irregular Periods	Y	N
Painful Periods	Y	N
History of Pregnancy Loss	Y	N
Other _____		

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2. Please tell me about any current or past injuries or accidents:

- Car: \_\_\_\_\_
- Sports: \_\_\_\_\_
- Horse/other animals: \_\_\_\_\_
- Broken bones/significant sprains: \_\_\_\_\_
- Infections: \_\_\_\_\_
- Other: \_\_\_\_\_

3. Please list medications (prescription or non-prescription) you have taken within the **past 60 days**:

*What did you take?*

*Reason:*

_____	_____
_____	_____
_____	_____

4. Please list medications (prescription or non-prescription) you have taken in the past for **more than 3 months**:

*What did you take?*

*Reason:*

_____	_____
_____	_____
_____	_____

5. Please list any herbs, nutritional supplements or natural remedies you take regularly.

\_\_\_\_\_  
\_\_\_\_\_

6. Please list anything else you would like me to know.

\_\_\_\_\_  
\_\_\_\_\_

## Part IV: Your Care in Our Office

*Please use this scale for the following question:*

**a) very important to me      b) important to me      c) not so important to me      d) does not apply**

How do you hope to benefit from care in our office?

- \_\_\_ Improvement of my physical symptoms
- \_\_\_ Improvement of my emotional/mental symptoms
- \_\_\_ Improvement of my ability to react or respond to stress
- \_\_\_ Improvement in enjoyment of life
- \_\_\_ Overall improved quality of life

I am responsible for payment: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*signature*

If not, who is? \_\_\_\_\_ Relationship to patient: \_\_\_ Spouse \_\_\_ Parent \_\_\_

Other: \_\_\_\_\_

***Thank you for choosing our office.  
We look forward to helping you to be successful on your journey to greater health and wellness.***