Dr. Julie Nyquist
Intake Form

Name: _____ Today's Date: _____/_____/_____

If Child – Guardian name: _____

Date of Birth: _____/_____/_____ Gender: _____ If pregnant, EDD: _____ / _____ / _____

Children and ages: _____

Address: _____

City: _____ State: _____ Zip: _____

Best Contact Number(s): _____

Email: _____ Occupation: _____

How did you discover our office? _____

Please complete this general health history survey, as it will provide your doctor with important information to better understand your history and your present needs.

Part I: Your Health Concerns or Symptoms and How They May Affect Your Life

1. Please describe your current health concern(s). **Is it related to a work injury or car accident?**

_____

_____

2. Please mark and describe areas of pain, discomfort, concern, past injuries or surgeries:

Comments:

_____
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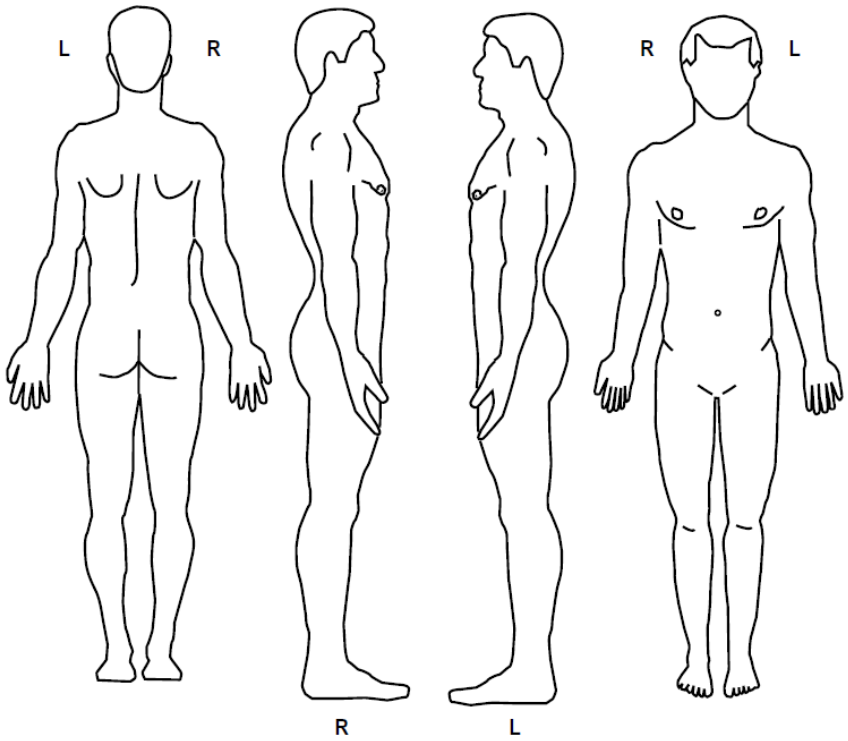

3. When did this situation or concern begin? _____

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	Current	Helpful?
Chiropractic			
MD/OB/Midwife/Doula			
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? _____

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

0 - no awareness of any stress **1 - slightly stressful**
2 - moderately 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
Bite guard	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
CPAP or Appliance	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 _____

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.