JOURNEY OF HEALTH
BLACK BAG MEDICINE

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To optimize time during your visit, please return this form no later than 3 business days prior to your appointment.

ADULT INTAKE FORM

Name:_____
Address:_____
City:_____ Postal Code:_____
Home Phone:_____ Cell Phone:_____
Age:_____ Date of Birth (MM/DD/YY):_____ Sex:_____
Email:_____
How did you hear about our clinic?_____

Primary Health Concerns:
Please list in order of importance to you.

1._____ 2._____
3._____ 4._____
5._____ 6._____

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have caused or contributed to your health problems?

Please list all former treatments that you have used, both conventional and alternative, and the degree of effectiveness of each treatment.

If female, are you currently pregnant? Yes ☐ No ☐

Medical History
Which childhood illnesses have you had?

☐ Rubella (German Measles – 3 day)	☐ Measles (2 week)	☐ Mumps
☐ Chicken Pox	☐ Whooping Cough	☐ Polio
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Roseola
☐ Asthma	☐ Other	

	Now	Past	Never		Now	Past	Never
Anemia	☐	☐	☐	Headache	☐	☐	☐
Allergies	☐	☐	☐	Heart murmur	☐	☐	☐
Alcohol abuse	☐	☐	☐	High blood pressure	☐	☐	☐
Arthritis	☐	☐	☐	Hyperthyroid	☐	☐	☐
Asthma	☐	☐	☐	Hypoglycemia	☐	☐	☐
Bleeding	☐	☐	☐	Hypothyroid	☐	☐	☐
Cancer	☐	☐	☐	Kidney disease	☐	☐	☐
Candida	☐	☐	☐	Liver dz/Jaundice	☐	☐	☐
Colitis	☐	☐	☐	Overweight	☐	☐	☐
Diabetes	☐	☐	☐	Pneumonia	☐	☐	☐
Drug use	☐	☐	☐	Rheumatism	☐	☐	☐
Eczema	☐	☐	☐	Tuberculosis	☐	☐	☐
Emphysema	☐	☐	☐	Ulcers	☐	☐	☐

Medications/Supplements:
Please list all of your present medications including drugs, supplements, homeopathics and herbs along with dosages. Include a separate page if needed.

Please list all past prescription medications.

How many times have you been treated with antibiotics?
_____

Do you have any allergies (drug, other substances, environmental)?

What symptoms do you experience with an allergy attack?

Check off any of the following types of allergy testing that you have had:

Intradermal	☐	Scratch	☐	Blood IgG food	☐
Food intolerance testing	☐	Kinesiology	☐	Blood IgE inhalant/food	☐

Do you frequently use any of the following?

Aspirin	☐	Laxatives	☐
Diet pills	☐	Antacids	☐
Alcohol	☐	How much per day or week? _____	
Tobacco	☐	Form and amt per day _____	
Caffeine	☐	Form and amt per day _____	
Recreational drugs	☐	Form and frequency _____	

Immunizations:
Please indicate what immunizations you have had and approximate year.

DPT (diphtheria, pertussis, tetanus)	☐	Haemophilus influenza	☐
Hepatitis A	☐	Hepatitis B	☐
MMR (measles, mumps, rubella)	☐	Smallpox	☐
Polio	☐	Tetanus booster	☐
Flu	☐	Other	☐

Please indicate if any caused adverse reactions:

Do you get regular screening tests by another doctor? (Pap, blood tests etc.)
Yes ☐ No ☐

Family History:
Please list ages and if deceased, what they died from and at what age.

Mother's side
Mother _____
Grandfather _____
Grandmother _____
Your sisters _____

Father's side
Father_____
Grandfather _____
Grandmother _____
Your brothers _____

Please indicate if a close relative has had any of the following:

Condition	Who?	Condition	Who?
Allergies		Hay fever	
Anemia		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Bleeding		Seizure/epilepsy	
Cancer		Sickle cell anemia	
Diabetes		Stroke	
Depression		Thyroid (hyper/hypo)	
Drug/alcohol abuse		Tuberculosis	
Eczema		Venereal disease (std)	
Glaucoma		Other	
Gout			

Social History:
Occupation:
_____

Do you enjoy your work? Or, is it a job that you feel you must do in order to make a living?
_____

How would you describe your relationship with your co-workers?
_____

Does income meet monthly expenses?
_____

Are you currently: Married ☐ Divorced ☐ Number of children:_____

How would you describe your family relationships?

Have you traveled outside of the US in the past year and where?

Do you exercise regularly? Yes ☐ No ☐

What do you do for exercise, how much, how often?

What are your hobbies?

How often do you drink: Wine:_____ Beer:_____ Other alcohol:_____

Do you use tobacco or have you in the past? Yes ☐ No ☐

Years since quitting:_____

Are you exposed to significant tobacco smoke (work, home etc.)? _____

Do you now or have you in the past used marijuana or other drugs? Yes ☐ No ☐

If yes, which drugs, how often and how long?_____

Have you ever been exposed to toxic chemicals, solvents or other possible toxins?

Do you make time for rest, relaxation or meditation during the day and/or before bed? How do you relax?

How would you describe the emotional climate of your home?

How stressful is your work or other aspects of your life? How well do you handle these stresses?

Sleep:

Do you have trouble falling asleep? Yes ☐ No ☐
Do you have trouble staying asleep? Yes ☐ No ☐

Home environment:

Are your home and work environments well-ventilated? Yes ☐ No ☐
Are your home and work environments excessively Moist ☐ Dry ☐

Diet:

Do you have any food intolerances or allergies? Please list.

Do you have any dietary restrictions (religious, vegetarian, vegan etc.)?
_____

How many meals do you generally eat each day?_____

Where do you usually buy your food?_____

Describe a typical day's diet:

Breakfast_____
Snack_____
Lunch_____
Snack_____
Dinner_____
Snack_____
Beverages (and total quantity)_____

Do you regularly consume any of the following (include approximate amount)?
Coffee ☐_____
Caffeinated teas ☐_____
Processed foods ☐_____
Refined foods ☐_____
Other food that you suspect may be harmful to your health_____

List any foods that you crave regardless of their nutritional value (includes chocolate, sweets, sour, salty, bread, rich/fatty food):

Are you thirsty? Yes ☐ No ☐

Amount of water you drink each day _____

Are you satisfied with your diet the way it is now? Why or why not?

Please mark next to the following symptoms that apply to you now or in the past.

Now	Past	Skin	Now	Past	Skin
		Dry, rough scaly, itchy skin			Pimples
		Rashes, warts			Loss of hair
		Moles, cysts			Hives
		Any of above change size/color			Scars
		Light/dark patches of skin			Color changes, ridges, pits, white spots on nails?

Now	Past	Lymphatic, Immune system	Now	Past	Endocrine
		Painful lymph nodes			Unexplained weight loss/gain
		Difficulty stopping bleeding			Prefers hot weather
		Bleeding from unusual places			Prefers cold weather
		Bruising easily			Can't stand cold
		Wounds heal slowly			Can't stand heat
		Anemia			Cold hands and feet
		Swollen glands			Fatigue- long term
		Fluid retention			Weakness
		Date of last blood tests			Increased thirst
					Increased hunger

Now	Past	Head	Now	Past	Ears
		Dizziness			Discharge from ears
		Severe headaches			Hearing problems
		Seizures, Convulsions			Sensitivity to noise
		Double vision			Pain in ears
		Fainting spells			Ringing in ears

Now	Past	Eyes	Now	Past	Nose
		Poor eyesight (near or far)			Nose bleeds
		Light hurts eyes			Sinus congestion
		Date of last glaucoma check			Nasal scabs/crusts

Now	Past	Mouth	Now	Past	Throat
		Sore mouth or throat			Persistent hoarseness
		Speech difficulties			Difficulty swallowing
		Bleeding gums			Recurrent strep throat
		Loss of teeth			Loss of voice
		Cold sores, blisters			Chronic sore throat or pain
		# of mercury amalgams			

Now	Past	Respiratory	Now	Past	Cardiovascular
		Unexplained fever			Chest pain when walking
		Chest pain when breathing			Chest pain when sitting/lying
		Wheezing			Ankle or abdominal swelling
		Difficulty breathing at night			Heart palpitations
		Chest congestion			Leg vein problems
		Dry sweats			Leg pain when walking
		Night sweats			Numbness/tingling in arm/leg
		Shortness of breath			Heart murmur
		Daily cough			

Have you ever been exposed to tuberculosis?_____

Have you ever had rheumatic fever or syphilis?_____

How far can you comfortably walk?_____

Do you get out of breath when climbing stairs?_____

Now	Past	Male Reproductive	Now	Past	Male Reproductive
		Prostate problems			Painful erection
		Swelling/lumps/pain in testicles			Difficulty with erection
		Discharge from penis			Premature ejaculation
		infertility			Difficulty with ejaculation

Date of last prostate exam?_____

Are you currently sexually active?_____

What type of contraception do you use?_____

Now	Past	Gastrointestinal	Now	Past	Gastrointestinal
		Constipation			Distress from fat/greasy food
		Diarrhea			Bad breath
		Alternating const/diarrhea			Body odor
		Change in bowel movements			Indigestion immed after meal
		Strain at stool			Bloating 2 – 3 hrs after meal
		Hemorrhoids			Pain 5 – 6 hrs after eating
		Black stool			Above symptoms worse stress
		Blood in stool			Heavy, full after eating
		Stool – yellow, grey, green			Nervous/shaky, better w sweets
		Stool – foul odor			Cravings sweets or alcohol
		Stool – undigested food			Irritable if miss meal
		# of bowel movements			Appetite change inc/decrease
		Vomiting blood			Loss of appetite
		Frequent or severe nausea			Insatiable appetite
		Heartburn			Weight change – inc/decrease
		Trouble swallowing			Diet but fail to lose weight
		Excessive belching			Eat but fail to gain weight
		Excessive lower bowel gas			Overweight
		Difficulty belching			Underweight
		Stomach cramps, colic			Compulsive eating
		Abdominal bloat/ distension			Addictive eating
		Anorexia			Yellowjaundice
		Bulimia			Bad taste in mouth
		Stomach/abdominal pain			Intestinal parasites suspected

Date of last sigmoidoscopy:_____

Now	Past	Female Reproductive	Now	Past	Female Reproductive
		Lumps in breast			Bleed/spot between periods
		Nipple discharge			Painful sex
		Breast pain			Lack of sexual desire
		Pelvic pain			Difficulty feeling sex. aroused
		Discharge from vagina			Never/seldom have orgasms
		Vaginal itching/burning			Menstruation excessive
		Genital eruptions			Menstruation absent

Do you perform regular breast self examinations?_____

Date of last mammogram:_____

Are you sexually active? _____

Type of contraception used?_____

Have you ever used birth control pills?_____

Did you experience any side effects?_____

Age of first menstruation _____ Did you have a normal puberty? _____

Is your cycle regular? Yes ☐ No ☐

Periods occur every _____ days and usually last _____ days.

Date of last period:_____

Date of last pap smear: _____ Was it normal? Yes ☐ No ☐

Have you ever had any problems with infertility? _____

# of pregnancies:_____ # of births:_____ # of miscarriages:_____ # of abortions:_____

Have you ever had any pregnancy complications?_____

Now	Past	Pituitary	Now	Past	Pituitary
		Failing memory			Low blood pressure
		Increased sexual desire			Decreased sexual desire
		Splitting headaches			Menstrual disorders
		High/low sugar tolerance			Intestinal bloating
		Abnormal thirst			Chunky hips or waist
		Ulcers, colitis			

Now	Past	Thyroid	Now	Past	Thyroid
		Overweight			Decreased appetite
		Difficulty losing weight			Nervousness
		Constipation			Heart palpitations
		Tired upon rising			Irritable/restless
		Easily fatigued			Increased appetite
		Dry or scaly skin			Underweight
		Chilly/sensitive to cold			Flush/get hot easily
		Mental slowness			Insomnia

Now	Past	Adrenals	Now	Past	Adrenals
		Easily stressed			Nails weak, ridged
		Easily/chronically fatigued			Tendency to get hives
		Dizziness			Rheumatism/arthritis
		Headaches			Poor circulation
		Hot flashes			Increased blood pressure
		Bronzing of the skin			Weak after getting a cold
		Craves salt			Facial hair for women

Now	Past	Sympathetic nervous system	Now	Past	Sympathetic nervous system
		Upset from acid foods			Cold extremities
		Dry eyes, nose, mouth			Light sensitive
		Nervousness			Decreased urine output
		Wounds that heal slowly			Heart pounds when lying
		Gag easily			Reduced appetite
		Very quick mentally			Frequent cold sweats

Now	Past	Parasympathetic nervous syst	Now	Past	Parasympathetic nervous syst
		Joint stiffness on rising			Frequent vomiting
		Muscle/leg/toe cramps			Alt. constipation/diarrhea
		Butterflies in stomach			Pulse slow/regular
		Digestion rapid			Breathing irregular
		Indigestion after eating			Poor circulation
		Perspiration scant/absent			Eyelids swollen/puffy
		Perspire easily/profusely			

Now	Past	Central/peripheral nerv. syst	Now	Past	Central/peripheral nerv. syst
		Loss of balance/fainting			Paralysis
		Dizziness regularly			Numbness/tingling
		Convulsions (seizures)			Temporary loss of sensation
		Blurred/double vision			Lack of strength
		Tremor (shaking, trembling)			Continual headache

Now	Past	Musculoskeletal system	Now	Past	Musculoskeletal system
		One arm or leg shorter			Muscle cramps
		Joint pain/stiffness swelling			Unusual redness of palms
		Backaches			Coughing, sneezing or straining at stools intensifies back pain
		Burning on soles of feet			

Now	Past	Mental status	Now	Past	Mental status
		Anxiety			Memory difficulties
		Restlessness			Mental confusion
		Excessive worry			Concentration difficulties
		Depression			Make a lot of mistakes
		Despair/discontent			Shy and timid
		Suicidal thoughts			Self-critical
		Suicidal attempts			Overly critical of others
		Loneliness			Lack of self-confidence
		Mood swings			Jealous and suspicious
		Prefer to be with people			Sensitive to noises
		Like to be alone			Organized and very neat
		Afraid when alone			Affectionate
		Confident and secure			Powerful and assertive

Please write a short description of how you see yourself:

Is there anything else that you believe is important for me to know about you?

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go along way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

1) a) Why did you choose to come to this clinic?

b) What do you know about our approach?

2) a) What three expectations do you have from this visit to our clinic?

b) What long term expectations do you have from working with our clinic?

c) What expectations do you have of me personally as a doctor?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)

0% 0 ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5 ☐ 6 ☐ 7 ☐ 8 ☐ 9 ☐ 10 ☐ 100%

4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Are you currently receiving healthcare? Yes ☐ No ☐

If yes, where and from whom:_____

If no, when and where did you last receive medical or health care?_____

What was the reason?_____

What are your most important health problems? List as many as you can in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

7) _____

Do you have any known contagious diseases at this time? Yes ☐ No ☐

If yes, what?_____