Two Rivers Wellness

1000 N 9th St, Suite 38•Grand Junction, CO 81501•970.812.3888

New Patient Intake

Welcome to Two Rivers Wellness. To help us provide you with the best possible care, please complete this form. If you need more space, feel free to write on the back. Feel free to ask us if you have any questions. This information will be kept in strict confidentiality.

Patient Name: _____ Date of Birth: ____ / ____ /_____ Age:_____

Biologically ❑ Male ❑ Female Occupation:_____

Email Address:_____ ❑ Check to receive our e-newsletter and special offers.

Street Address:_____

City:_____ State:_____ Zip:_____

Phone (day):_____ Phone (evening):_____

Phone (cell):_____

In case of emergency, contact:

Name:_____ Relationship:_____

Phone:_____

Address:_____

How did you hear about us? *Please be specific.*

Please describe your reason for today's visit:

Have you ever had this difficulty or a similar one before? ❑ Yes ❑ No — If yes, please explain:

Is it getting ❑ better ❑ worse or ❑ staying about the same?

What seems to make it feel better?

What seems to make it feel worse?

How committed are you to correcting your problem(s)?

Are you being treated elsewhere? ❑ Yes ❑ No

By whom?

What was the diagnosis?

What were the results of treatment?

Are you currently taking prescription or over-the-counter medicines, herbal remedies or dietary supplements? ❑ Yes ❑ No — If so, which ones?

Please continue onto the next page

Please check all of the boxes that are now or have been part of your health history.

- ❑ Addiction (drugs or alcohol)
- ❑ AIDS/ARC
- ❑ Allergies
- ❑ Anemia
- ❑ Appendicitis
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Bleeding Tendency
- ❑ Blood Pressure (low)
- ❑ Blood Pressure (high)
- ❑ Cancer
- ❑ Chicken Pox
- ❑ Diabetes
- ❑ Digestive Disorder
- ❑ Emotional Difficulties
- ❑ Emphysema
- ❑ Epilepsy
- ❑ Fatigue
- ❑ Gout
- ❑ Headaches
- ❑ Heart Disease
- ❑ Hepatitis
- ❑ Herpes
- ❑ HIV positive
- ❑ Hypoglycemia
- ❑ Injuries
- ❑ Insomnia
- ❑ Intestinal Parasites
- ❑ Measles
- ❑ Multiple Sclerosis
- ❑ Mumps
- ❑ Pacemaker
- ❑ Polio
- ❑ Rheumatic Fever
- ❑ Scarlet Fever
- ❑ Sexually Transmitted Disease
- ❑ Stroke
- ❑ Surgery (list) _____
  _____
  _____
  _____
- ❑ Thyroid Disorders
- ❑ Trauma (falls, accidents)
- ❑ Tuberculosis
- ❑ Ulcers
- ❑ Other: _____
  _____

Family Medical History

- ❑ Alcoholism
- ❑ Allergies (list)
  _____
  _____
- ❑ Arteriosclerosis
- ❑ Asthma
- ❑ Cancer
- ❑ Diabetes
- ❑ Heart Disease
- ❑ High Blood Pressure
- ❑ Seizures
- ❑ Stroke

How would you describe the state of your immune system?

❑ Excellent ❑ Good ❑ Fair ❑ Poor

Are you under any unusual stress right now? ❑ Yes ❑ No — **If yes, please describe:**

Which of the following is/are part of your lifestyle?

- ❑ Tobacco Smoking
- ❑ Coffee or Energy drinks
- ❑ Alcohol Drinking
- ❑ Recreational Drugs
- ❑ Birth Control Pills
- ❑ Special Diet
- ❑ Exercise
- ❑ Relaxation/Meditation
- ❑ Vitamins/Supplements

Please describe the foods you eat in a typical day:

Breakfast:

Lunch:

Dinner:

Snacks:

Please continue onto the next page

Symptom Review

Please put one check mark by a symptom you sometimes experience; use two checks for those which occur often, and three checks for symptoms that are a major concern.

Head and Face
❑ Headaches
❑ Dizziness
❑ Memory loss
❑ Other

Eyes
❑ Blurred vision
❑ Eyelid problem
❑ Pain
❑ Other

Ears
❑ Hearing difficulty
❑ Earaches
❑ Discharge
❑ Ringing
❑ Other

Nose
❑ Frequent colds
❑ Sinus trouble
❑ Bleeding
❑ Other

Mouth
❑ Dental problems
❑ Gum problems
❑ Tongue problems
❑ Lip problems
❑ Jaw problems
❑ Unusual tastes
❑ Other

Throat
❑ Sore throat
❑ Hoarseness
❑ Difficulty swallowing
❑ Other

Respiration
❑ Difficulty inhaling
❑ Difficulty exhaling
❑ Pain
❑ Cough
❑ Congestion
❑ Other

Heart and Chest
❑ Palpitations
❑ High blood pressure
❑ Tightness in chest
❑ Low blood pressure
❑ Difficulty lying flat
❑ Other

Circulation
❑ Bruise easily
❑ Bleed easily
❑ Cold limbs
❑ Other

Gastrointestinal
❑ Excessive thirst
❑ Never thirsty
❑ Excessive appetite
❑ Poor appetite
❑ Digestive pain
❑ Nausea
❑ Diarrhea
❑ Constipation
❑ Rectal bleeding
❑ Colon problems
❑ Other

Urination
❑ Frequent
❑ Difficult
❑ Painful
❑ Nighttime
❑ Bleeding
❑ Other

Skin
❑ Rashes
❑ Dryness
❑ Moles or lumps that change
❑ Excessive sweating
❑ Night sweating
❑ Rarely sweat
❑ Other

Neurological
❑ Nervousness
❑ Tremors
❑ Convulsions
❑ Numbness or tingling
❑ Lack of coordination
❑ Nerve pain
❑ Other

Sleep
❑ Insomnia
❑ Drowsiness
❑ Excessive dreaming
❑ Other

Energy Level
❑ Low
❑ High
❑ Other

Pain (please describe below)

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Other Comments:

_____
_____
_____
_____
_____
_____
_____

Women Only *(Men, please see your section at the bottom of the page)*

Are your or might you be pregnant? ❑Yes ❑ No ❑ Maybe. If yes, what month? _____

Please continue onto the next page

What method of birth control do you use? _____

Do you have regular PAP tests? ❑ Yes ❑ No. How often? _____

Are you experiencing unusually low or high sexual desire? Other difficulties? _____

Age at first menstruation:_____ Age at menopause: _____

Date of the first day of your last menstrual period: _____

Number of days of bleeding of last menstruation: _____

Usual length of cycle (from first day of bleeding until day before next bleeding): _____

Are your periods:

❑ Irregular: ❑ Short ❑ Long ❑ Variable
❑ Painful: ❑ Before ❑ After ❑ During
Relieved by: : ❑ Heat ❑ Cold ❑ Pressure
❑ Heavy bleeding
❑ Light bleeding
❑ Dark blood: ❑ Red ❑ Purple ❑ Brown
❑ Light blood
❑ Thick blood
❑ Watery blood
❑ Heavy clotting
❑ Stop and start again
❑ Spotting: ❑ Before ❑ After ❑ Mid-cycle

Do you have any pre-menstrual symptoms?

❑ Painful or swollen breasts
❑ Irritability
❑ Depression
❑ Crying
❑ Food cravings: _____
❑ Nausea
❑ Cramps or pain
❑ Other: _____
_____

Vaginal Discharge:

❑ Normal
❑ Watery
❑ Thick
❑ Yellow
❑ Clear or white
❑ Bad odor
❑ Itching
❑ Dryness
❑ Other: _____

Gynecological surgeries or diseases: (please describe)

❑ Ovaries: _____
❑ Uterus: _____
❑ Fallopian Tubes: _____
❑ Vagina: _____
❑ Breasts: _____
❑ Other: _____

Pregnancies

Total number: _____
Number of children: _____
Number of abortions or miscarriages: _____
Complications: _____
_____
How long ago was your last pregnancy? _____

Men Only

Do you experience: ❑ None of these

❑ Reduced libido
❑ Excessive libido
❑ Premature ejaculation
❑ Seminal emission (spontaneous ejaculation without sexual stimulation)
❑ Urinary frequency
❑ Impotence
❑ Genital discharge
❑ Pain associated with genitals
❑ Other_____

Please continue onto the next page