Scottsdale Lifestyle Medicine

New Patient Intake

Name: ______________________________________Date: ___________________

Address: ____

City: __________________________ State: _________________ Zip Code: ______________

Phone (home): ____________________ Cell: ________________ other: _________________

E-mail address: _______________________________________ Age: ___________________

Date of Birth: ______________________________________

Live: ☐ Alone ☐ w/Partner ☐ w/Parents ☐ w/Children ☐ other family ☐ Friends

Occupation: ☐ Work ☐ Unemployed ☐ Disabled ☐ Retired ☐ Volunteer ☐ Student

Current Occupation: ____________________________# of Hours Work/Volunteer____________

If retired, disabled or unemployed, list last occupation: ____________________________________

Next of kin or emergency contact: ____

Relationship: _________________________ Phone: _________________________________

How did you hear about our clinic? ____

Are you under the current care of physician? ☐ Yes ☐ No If so, with whom: ____________________

If not receiving healthcare, when did you last receive health care? ___________________________

What is/was the reason? ____

Do you currently have any contagious diseases? ☐ Yes ☐ No Please list: ______________________

Do you have any allergies? ☐ Yes ☐ No Please list: _____________________________________

What are your most important health concerns and what treatments have been used?

1. _______________________________ treatments used _____________________________

2. _______________________________ treatments used _____________________________

3. _______________________________ treatments used _____________________________

What service(s) are you here for today? ____

____

1) What led you to choosing this clinic?

2) What do you know about Lifestyle Medicine and how we work?

3) What three expectations do you have from today's visit at our clinic?

4) What three short-term expectations do you have from working with our clinic?

5) What three short-term expectations do you have from working with our clinic?

6) At this present time, how committed are you to addressing the underlying causes of your signs and symptoms that may relate to your lifestyle? (0= not committed and 10= completely committed). Please circle.

0 1 2 3 4 5 6 7 8 9 10

6) What types of daily or weekly lifestyle habits do you feel support or strengthen your health?

7) What types of daily or weekly lifestyle habits do you feel do not fully support your health?

8) What obstacles or challenges do you potentially anticipate that may undermine your health and following through on your treatment?

9) Who do you know that will sincerely support you consistently with the lifestyle change you will be making to regain your health and vitality?

10) What do you love doing; what brings you joy?

11. How satisfied are you with the following aspects of life? (0 = not satisfied, 10 = completely satisfied). Please circle:

Health:	0	1	2	3	4	5	6	7	8	9	10
Physical Environment:	0	1	2	3	4	5	6	7	8	9	10
Career:	0	1	2	3	4	5	6	7	8	9	10
Personal growth:	0	1	2	3	4	5	6	7	8	9	10
Family Friends:	0	1	2	3	4	5	6	7	8	9	10
Significant Other/romance:	0	1	2	3	4	5	6	7	8	9	10
Fun Recreation:	0	1	2	3	4	5	6	7	8	9	10

FAMILY HISTORY

Do you have a family history of any of the following (please check all that apply)?

☐ Cancer **☐ Diabetes** **☐ Heart Disease** **☐ High Blood Pressure**

☐Kidney Disease **☐ Epilepsy** **☐ Arthritis** **☐ Glaucoma**

☐Tuberculosis **☐ Stroke** **☐ Anemia** **☐ Mental Health Illness**

☐Asthma **☐ Hay Fever** **☐ Hives**

Any other relevant family history?____

____

CHILDHOOD/EARLY ADOLESCENT ILLNESSES

Which of the following have you had as a child?

☐ Scarlet fever **☐Diphtheria** **☐ Rheumatic fever** **☐ Mumps**

☐ **Measles** ☐ **German measles** ☐ **Chicken pox** ☐ **Shingles**

☐ **EBV (Mononucleosis)** ☐ **CMV (Cytomegalovirus)**

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

____Year__________

____Year__________

____Year__________

____Year__________

____Year__________

ALLERGIES

Any drugs? ____

Any foods? ____

Any environmental or chemical products? ______________________________

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking (including herbs)?

1) ______________________ 5) ______________________

2) ______________________ 6) ______________________

3) ______________________ 7) ______________________

4) ______________________ 8) ______________________

GENERAL INFORMATION

Height: ________________ Weight: _________ lbs. Weight 1 year ago: _______________ lbs.

Maximum Weight ever: _______________________When was this: ______________________

When during the day is your energy the best? ____________________Worst? ____________

Blood Type: ___________________ ☐ Unknown

FOOD

Please write the most typical foods you eat for each meal.

Breakfast: ____

Lunch: ____

Dinner: ____

Snacks: ____

To drink: ____

Lifestyle

For this section, PLEASE CIRCLE
Y=Yes (a condition you have now), N=No (never had) and P= in the Past (significant problem of past).

Main interests or hobbies: ____

Do you exercise? Y N If so, what kind and how often? __________________________________

Do you get an average of 6-8 hrs. of sleep?	Y N	Any major traumas?	Y N P
Do you enjoy your work?	Y N	Do you eat 3 meals a day?	Y N P
Do you take vacations? Y N Awaken rested?	Y N	Do you eat 3 meals a day?	Y N P
Do you spend time outside?	Y N	Do you eat 3 meals a day?	Y N P
Do you have a supportive relationship(s)?	Y N	Do you go on diets often?	Y N P

Sleep well? Y N

Do you drink cola/ sodas? Y N P

How many hours do you watch TV? _____

Do you have a spiritual practice? Y N P If yes, what? ______________________________

Review of Systems

MENTAL/EMOTIONAL

Rate your stress level on a scale of 0-10: ______

Sources of stress: ____

What practices do you have for stress management? ____

IMMUNE SYSTEM

Reactions to vaccinations? Y N P
Chronic Fatigue Syndrome? Y N P
Chronically swollen glands? Y N P
Lyme Disease Y N P
Autoimmune? Y N P
Chronic infections? Y N P
Slow healing? Y N P

ENDOCRINE

Hypothyroid? Y N P
Hypoglycemia? Y N P
Excessive thirst? Y N P
Fatigue? Y N P
Heat or cold intolerance? Y N P
Diabetes? Y N P
Excessive hunger? Y N P
Seasonal depression? Y N P

NEUROLOGICAL

Seizures? Y N P
Muscle weakness? Y N P
Loss of memory? Y N P
Vertigo or dizziness? Y N P
SKIN Rashes? Y N P
Acne, Boils? Y N P
Color Change? Y N P
Lumps? Y N P
Paralysis? Y N P
Numbness or tingling? Y N P
Easily stressed? Y N P
Loss of balance? Y N P
Eczema, Hives? Y N P
Itching? Y N P
Hair Loss? Y N P
Night Sweats? Y N P

SKIN

Rashes? Y N P
Acne, Boils? Y N P
Color Change? Y N P
Lumps? Y N P
Eczema, Hives? Y N P
Itching? Y N P
Hair Loss? Y N P
Night Sweats? Y N P

HEAD

Headaches? Y N P
Migraines? Y N P
Head Injury? Y N P
Jaw/TMJ problems Y N P

EYES

Spots in eyes? Y N P
Impaired vision? Y N P
Blurriness? Y N P
Color blindness? Y N P
Double Vision? Y N P
Cataracts? Y N P
Glasses or contacts? Y N P
Eye pain/strain? Y N P
Tearing or dryness? Y N P
Glaucoma? Y N P

EARS

Impaired hearing? Y N P
Earaches? Y N P
Ringing? Y N P
Dizziness? Y N P

NOSE and SINUSES

Frequent colds? Y N P
Stuffiness? Y N P
Sinus problems? Y N P
Nose Bleeds? Y N P
Hayfever? Y N P
Loss of smell? Y N P

MOUTH and THROAT

Frequent sore throat? Y N P
Teeth grinding? Y N P
Gum problems? Y N P
Dental cavities? Y N P
NECK Lumps? Y N P
Goiter? Y N P
Large amount of saliva? Y N P
Sores in mouth or throat? Y N P
Hoarseness? Y N P
Jaw clicks? Y N P
Swollen glands? Y N P
Pain or stiffness? Y N P

RESPIRATORY

Cough? Y N P
Spitting up blood? Y N P
Asthma? Y N P
Pneumonia? Y N P
Emphysema? Y N P
Pain on breathing? Y N P
Shortness of breath at night? Y N P
Tuberculosis? Y N P
Sputum/phlegm? Y N P
Wheezing? Y N P
Bronchitis? Y N P
Pleurisy? Y N P
Difficulty breathing? Y N P
Shortness of breath? Y N P
Breathing worse with lying? Y N P
Lung cancer? Y N P

CARDIOVASCULAR

Heart disease? Y N P
High/Low Blood Pressure? Y N P
Blood clots? Y N P
Phlebitis? Y N P
Rheumatic Fever? Y N P
Swelling in ankles? Y N P
Angina? Y N P
Murmurs? Y N P
Fainting? Y N P
Palpitations/Fluttering? Y N P
Chest pain? Y N P

GASTROINTESTINAL

Trouble swallowing? Y N P
Change in thirst? Y N P
Change in appetite? Y N P
Nausea/vomiting Y N P
Ulcers? Y N P
Jaundice (yellow skin)? Y N P
Gall Bladder disease? Y N P
Liver Disease? Y N P
Hemorrhoids? Y N P

Heartburn? Y N P
Abdominal pain? Y N P
Belching or passing gas? Y N P
Constipation? Y N P
Diarrhea? Y N P
Bowel Movements: How often? _____
Is this a change Y N
Black stools? Y N P
Blood in stool? Y N P

URINARY

Pain with urination? Y N P
Do you urinate often at night? Y N P
Frequent infections? Y N P

Increased frequency? Y N P
Inability to hold urine? Y N P
Kidney stones? Y N P

MUSCULOSKELETAL

Joint pain or stiffness? Y N P
Broken bones? Y N P
Muscle spasms or cramps? Y N P

Arthritis? Y N P
Weakness? Y N P
Sciatica? Y N P

BLOOD/PERIPHERAL

Easy bleeding or bruising? Y N P
Deep leg pain? Y N P
Varicose veins? Y N P

Anemia? Y N P
Cold hands/feet? Y N P
Thrombophlebitis? Y N P

MALE REPRODUCTIVE

Hernias? Y N P
Testicular pain? Y N P
Discharge or sores? Y N P
Sexually transmitted disease? Y N P
-If yes, please explain ____________________________
____

Testicular masses? Y N P
Prostate disease? Y N P
Impotence? Y N P
Premature ejaculation? Y N P
Are you sexually active? Y N P
Sexual orientation _________________

FEMALE REPRODUCTION

Age of first menses? ______________________________
Age of last menses? (if menopausal) ________________
Length of cycle in days? ______
Duration of menses in days? ______
Painful menses? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
If yes, what are your symptoms? _____________________
Number of pregnancies: ________________

Date of last annual exam/ PAP _______
Are cycles regular? Y N
Abnormal bleeding? Y N P
Pain during intercourse? Y N P
Clotting issues? Y N P
Discharge? Y N P
Birth control? Y N P
What type? _________________________
Breast pain/tenderness? Y N P

Number of live births: ________________
Number of miscarriages or abortions: _________
Menopausal symptoms? Y N P
Abnormal PAP? Y N P
Sexual difficulties? Y N P
Do you do self breast exams? Y N P
Breast lumps? Y N P

Nipple discharge? Y N P
Endometriosis? Y N P
Ovarian cysts? Y N P
Difficulty conceiving? Y N P
Cervical dysplasia? Y N P
Are you sexually active? Y N

DRUG/ALCOHOL/TOBACCO HISTORY:

Please indicate any substances used over the last 6 months as "current use".
Include amount used at one time, how many times used per day/week, and the length of time you have been using or have used in the past.

Substance	**Current Use**	**Amount**	**Frequency**	**Past Use**	**Length of Use**
Caffeine					
Alcohol					
Tobacco					
Marijuana					
Pain Killers					
Tranquilizers					
Inhalants					
Sleeping Pills					
Diet Pills					
Laxatives					
Steroids					
Methamphetamines					
Ecstasy					
Cocaine					
Heroin					
Other					

MENTAL HEALTH HISTORY

Have you ever been in counseling/therapy before? Yes No
If yes, did you find it helpful or effective?

Have you ever sought any alternative treatment for mental health? Yes No
If yes, what type of treatment?

Was it helpful or effective? Are you currently receiving mental health services? Yes No
If yes, please list name of practitioner(s) and type of service you are receiving:

Have you ever been diagnosed with a mental illness? Yes No
If yes, please list illness(es) and date(s) first diagnosed:

Has anyone in your family ever been diagnosed with a mental illness? Yes No
If yes, please list relationship(s) and diagnosis:

Have you ever been hospitalized for mental health concerns? Yes No
If yes, list date(s), length of stay, and reason for hospitalization:

Have you ever, or are you currently engaging in self-harm? Current Past Never

Have you ever, or are you currently contemplating suicide? Current Past Never

Have you ever attempted suicide Yes No
If yes, please list date(s) and method(s) of attempt:

Has anyone in your life ever attempted suicide? Yes No
If yes, what was their relationship to you?

Has anyone in your life committed suicide? Yes No
If yes, what was their relationship to you?

Have you contemplated harming someone else? Current Past Never

Have you ever been the victim of abuse(verbal, physical, sexual)? Yes No
If yes, at what age(s)

Please circle all symptoms/behaviors that you've experienced and indicate if they're currently problematic or have been in the past.

Distractibility	Current	Past
Hyperactivity/Excessive Energy	Current	Past
Impulsivity	Current	Past
Wide Mood Swings	Current	Past
Over Confidence	Current	Past
Shy/Timid	Current	Past
Changes in Appetite/Eating Behavior	Current	Past
Suspicion/Paranoia/Jealousy	Current	Past
Aggression/Fights	Current	Past
Hearing Voices	Current	Past
Visual Hallucinations	Current	Past
Irritability/Anger	Current	Past
Increased/Decreased Need for Sleep	Current	Past
Delusions	Current	Past
Sexual Problems/Promiscuity	Current	Past
Lack of Motivation	Current	Past
Loss of Pleasure/Interest	Current	Past
Withdrawal From People	Current	Past
Sadness/Depression	Current	Past
Low Self-Worth	Current	Past
Crying Spells	Current	Past
Loneliness	Current	Past
Guilt/Shame	Current	Past
Fatigue	Current	Past
Racing Thoughts	Current	Past
Anxiety/Worry	Current	Past
Poor Memory/Confusion	Current	Past
Panic Attacks	Current	Past
Fear Away From Home	Current	Past
Nightmares	Current	Past
Social Discomfort	Current	Past
Obsessive Thoughts	Current	Past
Thoughts of Death	Current	Past
Relationship Problems	Current	Past
Flashbacks	Current	Past
Reoccurring Disturbing Memories	Current	Past

CONSENT TO TREATMENT

I agree to abide by the guidelines of Scottsdale Lifestyle Medicine, LLC. I understand that the State of Arizona does not license or otherwise recognize Lifestyle medical doctors. Therefore, Dr. Borsand or any other Lifestyle doctor participating in my care atScottsdale Lifestyle Medicine are not permitted to diagnose or treat a given diagnosis of a disease/illness. The role of my Lifestyle doctor is supportive, adjunctive and consultative in nature to assist in my health and well-being. I further understand that my Lifestyle doctor may work with other physicians or health care providers. I further understand, if I need additional assistance or medical care, I will be referred to others within the community. I hereby request and consent to the performance of Lifestyle care and related procedures on me by the Lifestyle doctor. I have had an opportunity to discuss with Dr. Alexander Borsand, MD, ABLM and/or otherScottsdale Lifestyle Medicine personnel the nature and purpose of Lifestyle care and related procedures. I understand that results are not guaranteed and that neither Scottsdale Lifestyle Medicine, nor Dr. Borsand or any other office personnel warrant or guarantee any result or outcome. In agreement with federal and state law, I agree to allow Scottsdale Lifestyle Medicine to deliver the necessary care to me in order to provide continuity of care and treatment. Scottsdale Lifestyle Medicine and/or my Lifestyle doctor may obtain from any source and examine and use, or discuss and disclose, my medical records and information to its personnel and agents, other healthcare providers, medical records auditors, professional committees, care evaluators and governmental agencies. This information can include, but is not limited to: medical history, examinations, diagnoses, treatments any psychiatric, drug and alcohol abuse or genetic testing information, or HIV or AIDS information. This consent to release and obtain information is valid until revoked. I may revoke this consent in writing at any time, except with regard to disclosures that have already been made in reliance on such consent. I have read, or have had read to me, the above consent. I have also had an opportunity to ask questions about its contents, and by signing below, I agree to the treatment recommended by my Lifestyle doctor. I intend this consent form to cover the entire course of treatment for my present condition(s) and for any condition(s) for which I seek treatment at Scottsdale Lifestyle Medicine. I understand the fee, appointment, and cancellation policies as well.

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Signature of individual or guardian **Date**