Transformational Medicine, PLLC.
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INITIAL INTAKE/FIRST OFFICE CALL

Date: _____ Date of Birth:_____

Full Name: _____ Name preference: _____
Address: _____
City/St/Zip_____
Phone(s):Hm:_____Cell:_____Work:_____
Email: _____
Occupation: _____
What do you do for fun? _____
Who can we thank for your referral? _____
In case of an emergency, call: Name: _____ ph# _____
Relationship: _____

What brings you here today?

_____
_____
_____

Medical History: (conditions/illnesses/accidents/injuries)

_____
_____
_____
Any surgeries? _____

Family History:
Mother: _____
Father: _____
Siblings: _____
What is your current form of "family"? _____

Medications:_____
_____
Supplements:_____
_____
Allergies or adverse reactions to anything? _____

Social History:
Do you smoke? Y__N__ If yes; how much/for how long?_____
Do you drink? Y__N__ If yes; how much/how often?_____
Do you exercise? If so what and how often:_____
Describe your sleep:_____
Bowel habits: Any constipation/diarrhea?_____
How often do you urinate?_____

For Women:
If you are still menstruating, describe your cycles:_____
_____
If not, describe your menopause: _____
Pregnancies: how many/# of live births/how was birth & pregnancy for you?
_____
_____
What forms of birth control have you used in your life? _____
_____
Are you still sexually active? Yes or No Are you happy with your sex life? Yes or No
Do you get regular pelvic exams? Yes or No Are you having safe sex? Yes or No
Any past or current sexually transmitted diseases? Yes or No If yes, what was it? _____
_____

For Men:
Are you still sexually active? Yes or No Are you happy with your sex life? Yes or No
Are you having safe sex? Yes or No
Any past or current sexually transmitted diseases? Yes or No If yes, what was it? _____
_____
Have you had a prostate exam? _____ Ever had your PSA tested? _____

Thank you!

BELOW: FOR DR'S USE ONLY*

VITALS: BP: _____ Temp:_____ Pulse:_____

Physical Exam = Review of Systems:
Constitutional: _____
HEENT: _____
_____
Lymph nodes: _____
Lungs: _____
Heart: _____
Abdomen: _____
Rectum: _____
Genitalia: _____
Reproductive:_____
Musculoskeletal: _____
Nervous System: _____

- Mental status
- Cranial nerves
- Motor strength
- Sensation (light touch/sharp/vibration/position)
- Reflexes
- Cerebellar function, gait

Any other concerns for followup...

LABS/DIAGNOSTICS/EKG'S?_____

Assessment:_____

PLAN: