blŭm center for health™

34 Rye Ridge Plaza. Rye Brook. NY 10573 | 914.652.7800

Patient Intake Form

Welcome to the Blum Center for Health! This is the first step on your path to wellness and we look forward to meeting with you in person.

We have created this comprehensive intake form for you to fill out in advance of coming to see us. We realize it may take some time for you to go through, but this will give you an opportunity to think and remember about your past medical history, about your current medical concerns and reasons for seeking our help. Having all this information on paper will be very helpful when you come in and we will review this together during your medical or nutrition consultation. We have learned that it is often hard for our patients to remember everything when sitting in front of us!

See you soon,

Blum Center for Health Medical Team

We ask that you please refrain from wearing perfume, cologne, or scented body lotions at the time of your visit since we have many patients with severe allergies. Thank you in advance for your consideration.

Section 1: Patient Information

Today's Date ___________

Name____

Age_____ Date of Birth ___________ Social Security #_________________________ Gender ___________

Occupation: _______________________________________

Primary Address

Street	City	State	Zip

Alternative Address

Street	City	State	Zip

Home Phone:	Work Phone:
Cell Phone:	Fax:
Email Address:	Permission to leave a message on your answering machine? Yes___ No ___
Emergency Contact:	Emergency Phone:

Referred by:	Book	Website	Media	Friend or Family	Other____________

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Insurance Information

Insurance Company________________________________ Name of Insurer___________________________________ __ Self __Spouse __Parent	Plan #______________________ State_________
Insurance Claims: We do not accept insurance. We are out of network for all private insurance and opted-out of Medicare. We will provide you with an insurance form for you to submit. We are not responsible for any billing issues between you and your insurance carrier after your appointment. Therefore, any issues with your insurance claim must be handled by the patient directly.	
Primary Care Physician___________________________ Phone #______________________ *Please maintain your primary care provider, as we do not provide primary care.*	

Section 2: Medical History

What brings you to Blum Center for Health? ____

____

____

If you had 3 wishes for our visit today, what would they be? ______________________________

____

____

____

When did you last feel well? ____

____

____

____

____

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Symptom Review

Please check if you have had these symptoms in the past and/or in the recent 6 months (including now).

Skin Problems

Now Past

___ ___ Acne
___ ___ Athlete's foot
___ ___ Bumps back of arm
___ ___ Cellulite
___ ___ Dandruff
___ ___ Dark circles under eyes
___ ___ Ears get red
___ ___ Easy Bruising
___ ___ Eczema
___ ___ Herpes- genital
___ ___ Cold Sores
___ ___ Hives
___ ___ Jock itch
___ ___ Change in moles
___ ___ Oily skin
___ ___ Psoriasis
___ ___ Rash
___ ___ Red Face
___ ___ Sensitive to bites
___ ___ Sensitive to poison ivy
___ ___ Shingles
___ ___ Skin cancer
___ ___ Skin itching
___ ___ Skin dryness
___ ___ Strong body odor

Head, Eyes, & Ears

Now Past

___ ___ Distorted smell
___ ___ Distorted taste
___ ___ Bad breath
___ ___ Ear fullness
___ ___ Ear pain
___ ___ Ear ringing
___ ___ Jaw pain
___ ___ Eye pain
___ ___ Vision
___ ___ Sinus
___ ___ Migraine
___ ___Headache
___ ___ Noise sensitivity
___ ___ Hearing problem

Nails

Now Past

___ ___ Bitten
___ ___ Brittle
___ ___ Curve up
___ ___ Fungus
___ ___ Peeling
___ ___ Ridges
___ ___ Thickened
___ ___ White spots/lines

Cardiovascular

Now Past

___ ___ Chest Pain
___ ___ Breathlessness
___ ___ Palpitations
___ ___ Pain in Calves
___ ___ Swollen ankles
___ ___ Varicose veins

Respiratory

Now Past

___ ___ Bad Breath
___ ___ Cough
___ ___ Hay fever
___ ___ Hoarseness
___ ___ Nasal stuffiness
___ ___ Nose bleeds
___ ___ Post nasal drip
___ ___ Out of breath
___ ___ At Rest
___ ___ Exercise
___ ___ Sinus fullness
___ ___ Sinus infection
___ ___ Snoring
___ ___ Sore throat
___ ___ Wheezing
___ ___Winter stuffiness

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Digestion

Now Past

___ ___ Bloating after eating
___ ___ Blood in stool
___ ___ Burping
___ ___ Constipation
___ ___ Anal itching
___ ___ Trouble chewing
___ ___ Diarrhea
___ ___ Difficulty chewing
___ ___ Dry mouth
___ ___ Passing gas
___ ___ Fissures
___ ___ Foods "repeat"
___ ___ Heartburn (reflux)
___ ___ Hemorrhoids
___ ___ Intolerance to:
___ ___ Lactose
___ ___ All milk product
___ ___ Gluten
___ ___ Corn
___ ___ Eggs
___ ___ Fatty Foods
___ ___ Other _________
___ ___ Yellow eyes/skin
___ ___ Abdominal Pain
___ ___ Mucus in stools
___ ___ Nausea
___ ___ Strong stool odor
___ ___Undigested food in stool
___ ___ Vomiting

Muscle/Bone

Now Past

___ ___ Muscle twitching
___ ___ Muscle pain
___ ___ Joint pain
___ ___ Joint stiffness
___ ___ Tendonitis
___ ___ Back pain

Mood/ Nerves

Now Past

Difficulty:

___ ___ Concentrating
___ ___ With balance
___ ___ With judgement
___ ___ With memory

___ ___ Dizziness
___ ___ Light Headed
___ ___ Fainting
___ ___ Numbness
___ ___ Anxiety
___ ___ Fearfulness
___ ___ Depression
___ ___ Suicidal thoughts
___ ___ Other phobias
___ ___ Panic attacks
___ ___ Paranoia
___ ___ Hallucinations
___ ___ Seizures
___ ___ Tingling
___ ___ Tremor

Endocrine/Immune

Now Past

___ ___ Cold hands/feet
___ ___ Cold or heat intolerance
___ ___ Fatigue
___ ___Weight gain
___ ___Get sick a lot
___ ___Swollen lymph nodes

Male Reproductive

Now Past

___ ___ Discharge from penis
___ ___ Ejaculation problem
___ ___ Genital pain
___ ___ Impotence
___ ___ Lumps in testicles
___ ___ Poor libido (sex drive)

Female Reproductive

Now Past

___ ___ Breast cysts
___ ___ Breast tenderness
___ ___ Ovarian cyst
___ ___ Poor libido (sex drive)
___ ___ Pelvic Pain
___ ___ Infertility
___ ___ Vaginal discharge
___ ___ Vaginal itch
___ ___ Vaginal pain
___ ___ Bumps
___ ___ Sores/ulcers
___ ___ Bleed between periods
___ ___ Pain with sex
___ ___ Difficulty having orgasm

Menopause

Now Past

___ ___ Hot flashes
___ ___ Mood swings
___ ___ Concentration
___ ___ Memory
___ ___ Vaginal dryness
___ ___ Painful sex
___ ___ Decreased libido
___ ___ Weight gain
___ ___ Frequent urination

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Urinary

Now Past
___ ___ Hesitancy
___ ___ Frequent UTI
___ ___ Pain/Burning
___ ___ Urgency
___ ___ Leaking

Premenstrual

Now Past
___ ___ Bloating
___ ___ Breast tenderness
___ ___ Food cravings
___ ___ Sleep change
___ ___ Fatigue
___ ___ Migraines
___ ___ Depression/Mood changes

Menstrual

Now Past
___ ___ Cramps
___ ___ Heavy periods
___ ___ Irregular periods
___ ___ No periods
___ ___ Spotting
___ ___ Long periods

Past and Current Medical Diagnosis

Check off if you have been diagnosed with any of the conditions below, either presently or in the past (prior to 6 months).

Gastrointestinal

Now Past
___ ___ Irritable Bowel Syndrome
___ ___ Inflammatory Bowel Disease
___ ___ Crohn's disease
___ ___ Ulcerative Colitis
___ ___ GERD
___ ___ Celiac Disease
___ ___ Gastritis or Peptic Ulcer Disease
___ ___ Other ____________________

Cardiovascular

Now Past
___ ___ Heart attack
___ ___ Stroke
___ ___ Elevated Cholesterol
___ ___ Arrhythmia
___ ___ High blood pressure
___ ___ Rheumatic fever
___ ___ Other_________

Cancer

Now Past
___ ___ Lung Cancer
___ ___ Breast Cancer
___ ___ Ovarian Cancer
___ ___ Colon Cancer
___ ___ Prostate Cancer
___ ___ Uterine Cancer
___ ___ Other________

Musculoskeletal or Pain

Now Past
___ ___ Osteoarthritis
___ ___ Fibromyalgia
___ ___ Chronic Pain
___ ___ Other______

Skin Disease

Now Past
___ ___ Eczema
___ ___ Psoriasis
___ ___ Acne
___ ___ Melanoma
___ ___ Skin Cancer
___ ___ Other_________

Respiratory Disease

Now Past
___ ___ Asthma
___ ___ Chronic Sinusitis
___ ___ Bronchitis
___ ___ Emphysema
___ ___ Pneumonia
___ ___ Tuberculosis
___ ___ Sleep Apnea
___ ___ Other_________

Patient Intake Form

Metabolic/Endocrine

Now Past
___ ___Type 1 Diabetes
___ ___Type 2 Diabetes
___ ___Hypoglycemia
___ ___Metabolic Syndrome
___ ___Insulin Resistance
___ ___Hypothyroidism (Low thyroid)
___ ___Hyperthyroidism (over reactive)
___ ___ Bulimia
___ ___ Eating Disorder
___ ___ Polycystic Ovarian Syndrome (non-specific)
___ ___ Anorexia
___ ___ Binge Eating Disorder
___ ___ Other _______________

Genital and Urinary

Now Past
___ ___Kidney Stones
___ ___Gout
___ ___Frequent UTI
___ ___Fibroids
___ ___Endometriosis
___ ___Adenomysosis
___ ___Uterine Anomoly
___ ___Frequent Yeast Infections
___ ___Interstitial Cystitis
___ ___Erectile Dysfunction
___ ___Sexual Dysfunction

Inflammatory/ Autoimmune

Now Past
___ ___ Lupus SLE
___ ___ Autoimmune Thyroid
___ ___ Hashimoto/Graves
___ ___ Rheumatoid Arthritis
___ ___ Chronic Fatigue Syndrome
___ ___ Immune Deficiency Disease
___ ___ Severe Infectious Disease
___ ___ Food Allergies
___ ___ Environmental Allergies
___ ___ Multiple Chemical Sensitivities
___ ___ Lyme Disease
___ ___ Latex Allergy
___ ___ Mono or Epstein Barr
___ ___ Other _________________

Neurologic/Mood

Now Past
___ ___Depression
___ ___Anxiety
___ ___Bipolar Disease
___ ___Schizophrenia
___ ___Headaches
___ ___Migraines
___ ___ADD/ADHD
___ ___Autism
___ ___Mild Cognitive Impairment
___ ___Parkinson’s Disease
___ ___Multiple Sclerosis
___ ___Seizures
___ ___Other____________

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Patient Intake Form

Medication and Allergies

Current Medications – Use a separate sheet if necessary

Medication	Reason for use

Allergy Information

Medication/ Supplement/ Food	Reaction

Prolonged or regular use of NSAIDS (Advil, Aleve, etc.), Motrin, Aspirin, Tylenol
Prolonged use of acid Blocking Drugs (Tagamet, Zantac, Prilosec, etc.)
Use of steroids (Prednisone, inhalers) in the past
Prolonged use of antibiotics
Prolonged use of Antidepressants

Nutritional Supplements (Vitamins, Herbs, Homeopathy)

Supplement/Brand	Reasons for Use

Family History

Condition	Who?	Diagnosis
Cancer		
Autoimmune		
Cardiovascular		
Diabetes		
Mental Illness		
Other____________________		
Other____________________		

Patient Intake Form

Past Medical History

Your Birth History

Term ___ Premature ___

Pregnancy or Birth Complications

____

____

____

Your Childhood History
(check if yes)

___Lots of sugar/candy as child
___Ear infections
___Recurrent strep throat
___Lots of antibiotics
___Stomach ache
___Mono
___Other childhood illnesses

Dental History
___Many cavities
___Silver mercury fillings. How many?
_____
___Gold fillings
___Root Canals
___Implants
___Tooth Pain
___Bleeding Gums
___Gingivitis
___Floss regularly

Injuries

___Back injury
___ Neck injury
___Head injury
___Broken bones
___Other __________

FOR WOMEN
Obstetric History
Check box if yes and provide#

Pregnancies____
- ___Caesarean
- ___Ectopic
- ___Vaginal deliveries
- ___Miscarriage
- ___Abortion
  - Medical
  - Surgical
- Living children___

___Post-Partum Depression
___Toxemia
___Gestational Diabetes
___Baby over 8 lbs
___Breast feeding
- How long?____

Menstrual History
Age at first period ____
Menses Frequency ____
-Length ________

	Yes	No
Long periods?	___	___
Pain?	___	___
Clotting?	___	___

Has your period ever skipped?_____
For how long?_____
Last Menstrual period_________
Use of contraception
Birth Control Pills
If current, # of years____
If in past, when ____
___Patch
___Nuva ring
How long?____
___Condom
___Diaphragm
___IUD
What Kind?__________
___Partner vasectomy
___Implant / rod
___Sterilization
Tubal ligation___
Essure/coils___

Use with Menses
___Tampons
___Pads
___Organic disposable
___Cotton reusable
___Menstrual cups
___Menstrual underwear

Menopause History
Age of last period____
Hormone replacement therapy
Currently? #of years ___
Past? When?____

Patient Intake Form

Gynecological History

__ Abnormal Pap
__ Abnormal HPV test
__ Genital Warts
__ Colposcopy
__ Colposcopy Treatment
Cryo__ Leep__
__Pelvic Infections

__ HPV Vaccine
__ Intimate partner violence or other sexual trauma

Did your mother take DES or other fertility drugs to get pregnancy with you? _________

Past Surgical History and Hospitalization

Date	Condition/reason

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Preventative/ Diagnostic Testing

Check box if yes and provide date

Full Physical Exam __________

Bone Density _______________

Colonoscopy________________

Ultrasound__________________

CT Scan____________________

MRI_______________________

EKG_______________________

Cardiac Stress Test___________

EBT Heart Scan______________

Upper GI Series_______________

Upper Endoscopy_____________

Hemoccult Test-Stool test for blood _______

Men's Preventative testing

Check box if yes and provide date

Last PSA____________________

PSA Level: 0-2   2-4   4-10   >10

Last Prostate exam (rectal)

Results__________________

Women's Preventative Testing

Check box if yes and provide date

Last mammogram____________

Need a biopsy? Date__________

PAP test date_______

Normal__ Abnormal__

HPV test

Normal__ Abnormal__

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Environmental or Other Exposures and Detox Assessment

Adverse reaction to:

- Caffeine:

  Irritable__ Wired__ Aches & Pains___
- Monosodium Glutamate (MSG)___
- Aspartame (NutraSweet)____
- Bananas___ Garlic___ Onion____ Cheese___
- Citrus foods__ Chocolate__ Alcohol__
- Red wine__
- Sulfite Containing foods (Wine, Dried fruit, Salad bars)
- Preservatives (ex. Sodium Benzoate) ___
- Other_________

You are affected by:

- Cigarette smoking __
- Perfumes/Colognes
- Auto exhaust fumes__
- Other_____

In your work or home environment,

Are you exposed to:

- Chemicals__
- Electromagnetic Radiation__
- Mold__

History of:

Jaundice (turning yellow) __

Gilbert's syndrome or a liver disorder___

Explain___

Exposure to harmful chemicals such as:

- Herbicides__
- Insecticides__
- Pesticides___
- Organic Solvents__
- Heavy Metals__
- Other__________

Chemical Name, Date, Length of Exposure

____

____

____

____

- Dry clean your clothes frequently_____
- Lived or worked in a damp or moldy environment or had other mold exposures_____
- Do you have any pets/farm animals?

  ____
- Work with oil based paint as painter? ________
- History of drinking problem? (see Lifestyle section for detailed questions) _______________

Patient Intake Form

Social and Personal History

Relationships:

Single Married Divorced Gay/Lesbian Long Term Partnership

List Children:

Child's Name	Age	Gender

Who is living in Household? Number ___

Names____

Their Employment/Occupation____

Where do you find emotional support? Check all that apply:

Spouse Family Friends Religious/Spiritual Pets Other_______________

Lifestyle and Self-Care

Smoking:

Currently Smoking:

How many years? _____

Packs per day: _______

Attempts to quit: ______________________

Previous Smoking:

How many years? ______

Packs per day? ________

Second hand smoke exposure

____

Patient Intake Form

Alcohol Intake:

How many drinks currently per week?
1 drink= 5 oz. Wine, 12 oz. Beer, 1.5 oz. spirits

None 1-3 4-6 7-10 >10

Previous Alcohol Intake:

Mild Moderate High None

__ Been told you should cut down alcohol intake

__ Feel guilty about alcohol intake

__ Have been unable to remember what you did during drinking episode

__ Get into arguments or physical fights when drinking

_ Been arrested or hospitalized due to drinking

_ Thought about getting help to control or stop your drinking

Other Substances:

Caffeine intake (cups/day):

Coffee 1 2-4 > 4 a day

Tea 1 2-4 > 4 a day

Caffeinated or Diet Soda Intake:

12 oz. can/bottle/day 1 2-4 > 4 a day

List favorite type (ex. Diet coke, Pepsi):

____

Recreational Drugs

Type __________________________________

Exercise, Stress, and Sleep

Exercise - Current Exercise Program

Activity	Type	How Often/Week	How Long
Stretching			
Cardio/ Aerobics			
Strength			
Other (Yoga, Pilates, etc.)			
Sports or Leisure Activity			

Rate your level of motivation for including exercise in your life? Low Medium High

List problems that limit activity ____

Do you feel unusually fatigued after exercise? Yes No

If yes, please describe____

Do you unusually sweat when exercising?

Patient Intake Form

Stress/Coping

Check all that apply

I have been in counseling in the past.

I have excessive amount of stress.

I have trouble handling stress in my life.

I am currently in therapy. Describe __________________________

I practice meditation or a relaxation technique. How often? ______

Daily Stressors: Rate on a scale 1-10 (10 being the worst)

___Work ___Family ___Social ___Finances ___Health ___Other

Check all that apply:

Yoga Meditation Imagery Breathing Tai Chi Prayer Other_________________________

What do you do for fun? ____

Spirituality:

Are you apart of a religious or spiritual community? Describe ____

Do you have spiritual beliefs that help you deal with health, stress, and other life issues? ____________________

Sleep:

Average number of hours you sleep per night? >10 8-10 6-8 <6

What time do you go to sleep? _____________ Wake up? _________________

Check all that apply

Trouble falling asleep

Still feel tired in the morning

Wake up during the night and can’t fall back asleep

Snoring is an issue. You or your partner? ____________

Rely on sleeping pills

Patient Intake Form

Nutrition and Diet

Nutrition History:

Have you ever had a nutrition consultation? Yes No

Have you made any changes in your eating habits because of your health? Yes No

Descibe____

Do you currently follow a special diet or nutritional program? Yes No

Check all that apply:

Low fat High Protein Low Sodium Diabetic No Dairy

Low Carb No Wheat Gluten Restricted Vegan Vegetarian

Specific program followed for Weight Loss/ Maintenance type: ____________________________________

Other: ____

How often do you weigh yourself? Daily Weekly Monthly Rarely Never

Do you avoid any foods? Yes No

If yes, explain type and reason____

If you could only eat a few foods a week, what would they be? ____________________________________

How many meals do you eat out per week? 0-1 1-3 3-5 >5

Do you grocery shop? Yes No. If no, who does? ______

Do you cook? Yes No. If no, who does? ______

Do you read labels? Yes No

Check all factors that apply to your current lifestyle and eating habits.

Fast eater
Erratic eating pattern
Late night eating
Dislike healthy food
Time constraints
Travel frequently
Poor snack choices
Love to eat
Eat because I have to
Struggle with eating issues
Have a negative relationship to food
Eat more than __% away from home

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Check all factors that apply to your current lifestyle and eating habits.

Non-availability of healthy food

Do not plan meals or menu

Reliance on convenience items

Eat too much under stress

Eat too little under stress

Don’t care to cook

Eating in the middle of the night

Confused about nutrition advice

Emotional Eater (eat when sad, lonely, depressed, bored)

Significant other or family members don’t like healthy food

Significant other or family members have special dietary needs or food preferences

The most important thing I should change about my diet to improve my health is: ___________________________

____

Height (Feet/Inches) _____

Current Weight _____

Usual Weight Range+/- 5lbs. _____

Desired Weight Range+/- 5lbs. _____

Highest Adult Weight_____

Lowest Adult Weight _____

Weight Fluctuations (>10 lbs.)? Yes No

Body Fat % _____

Readiness to Change

In order to improve your health, how willing are you to:

Significantly modify your diet:

5 4 3 2 1

Modify your lifestyle (e.g., work demands, sleep habits):

5 4 3 2 1

Take several nutritional supplements each day:

5 4 3 2 1

Keep a record of everything you eat each day:

5 4 3 2 1

Practice a relaxation technique:

5 4 3 2 1

Engage in regular exercise:

5 4 3 2 1

Comments:

____

How confident are you of your ability to organize and follow through on the above health related activities?

5 4 3 2 1

At the present time, how supportive do you think the people in your household will be to your implementing the above changes? 5 4 3 2 1

Comments____