Orville R. Weyrich, Jr. PhD NMD

NEW PATIENT INTAKE FORM

Name:_____ Date of birth: _____ Date:_____

What are your top 3 health goals you wish to address at today's visit? How long have you had these issues?

1. _____ Since:_____
2. _____ Since: _____
3. _____ Since: _____

What factors do you feel may be contributing to your current state of health?_____

_____

What is your current level of commitment to addressing these issues?

- ☐ I am willing to make any changes and do whatever is necessary
- ☐ I am willing to make some changes in my lifestyle to feel better
- ☐ I may consider changes if absolutely necessary to feel better
- ☐ I am specifically looking for medication/surgical alternative
- ☐ I am here to learn about my healthcare options and what you offer

Do you have any chronic health problems or other diagnosis *(please list and give date when it was diagnosed)*

_____

_____

Are you currently under the care of any other health professional? YES/NO

If yes, name and reason: _____

When was your last complete medical check-up? _____

Date and type of last labs: _____

Results of these labs: _____

Please list all **current medications and supplements** (***include name/brand, dose, how long have been taking, reason for taking, and who prescribed it)*:** Please attach additional sheet if necessary:

Meds/supplement	**Dose**	**Been on it since?**	**Reason for taking**	**Prescribed by**

3543 N 7th Street▪Phoenix, AZ 85014▪ Phone: (480) 423-6952
www.DrWeyrich.com *** e-mail Orville2@DrWeyrich.com

Do you have any known allergies to drugs, foods or substances? YES/NO

If "yes", please

specify:_____

Have you been **immunized** for any of the following (please circle): Tetanus Pertussis MMR Hemphilus

Chicken Pox Flu shot Hep B Pneumonia Other: _____

Have you ever had a bad reaction/complications to a vaccine? _____

Surgical and trauma history (operations/injury, reason, date, doctor's name):

_____

PAST MEDICAL HISTORY AND FAMILY HISTORY

(Place a check mark if you or your family ever have been diagnosed with the any of these diseases)

	You	Mother	Father	Grandparents	Sibling(s)	Spouse	Children
AIDS							
Alcoholism							
Allergies							
Alzheimers							
Anemia							
Arthritis							
Asthma							
Birth defects							
Bleeding disorder							
Breast cancer							
Cancer							
Colon cancer							
COPD							
Depression							
Diabetes							
Emphysema							
Epilepsy							
Glaucoma							
Heart attack							
Heart trouble							
Hypertension							
Irritable bowel							
Kidney disease							
Liver disease							
Mental illness							
Migraines							
Pneumonia							
Prostate cancer							
Sickle cell anemia							
Stroke							

Suicide							
Tuberculosis							
Ulcers							
Other							

Social status: Single___ Married:____ Divorced:____Widowed:_____ Separated:_____

Children? How many? :_____

How would you describe your current emotional state?_____

Do you enjoy your work? YES/NO If no, why not? _____

How many hours do you sleep at night? _____ hrs Do you wake up rested? YES/NO

Please fill in below with the foods and beverages that represent a typical day for you:

Breakfast: _____

Lunch: _____

Dinner: _____

Snack: _____

Which, if any particular food do you strongly crave?

_____

Amount of water you drink daily: _____ Soda: _____ Milk: _____ Coffee/Tea: _____

How often do you eat out weekly? _____/wk What restaurants do you frequent? _____

_____

Do you smoke? YES/NO If yes, number of years _____ Packs per day ?_____

Have you ever smoked? YES/NO If yes, when and how did you quit? _____

Do you drink alcohol? YES/NO If yes, # of drinks per week _____ type: _____

Do you exercise? YES/NO If yes, type and frequency _____

Do you use recreational drugs? YES/NO If yes, type/frequency _____

Do you use artificial sweetener? YES/NO type/reason _____

_____

Please place a check mark next to the symptoms you are currently experiencing or have experienced in the past. If there are one or more words in a line that describe your specific problem, please circle those words.

GENERAL SYMPTOMS	Now	Past		EYES	Now	Past
Tired, weak, lack of energy				Nearsightedness or farsightedness		
Depression, melancholy, moodiness				Blurred or failing vision		
Worry, anxiety, nervouseness				Dry, burning or itching eyes		
Irritability				Eyes water excessively		
Sleeplessness or sleeping too much				Eyes sensitive to light		
Frequent colds or other illnesses				Night blindness		
Excess sweating – during the day/night				Blood shot or puffy eyes		
Rarely sweats				Dark circles under eyes		
Dizziness, fainting, convulsions				Other:		
Loss or gain of weight				**EARS**	**Now**	**Past**
Other:				Earaches		
HEAD	**Now**	**Past**		Noises or ringing in the ears		
Headaches: Frontal, sides, occiput/neck				Ear discharge		
Pain is sharp, dull, with nausea and vomiting				Loss of hearing		
Recurrent : weekly, monthly, seasonally				Excessive ear wax		
Swelling, nodules, ulcers, wounds of scalp				Other:		
Other:						
NOSE/THROAT/NECK	**Now**	**Past**		**NEUROLOGICAL**	**Now**	**Past**
Hay fever, sinusitis, runny nose				Numbness, tingling in hands/feet		
Dry mouth or nose, nose bleeds				Difficulty feeling heat/coldness		
Cracks in corners of mouth				Pain? Specify:		
Dry or chapped lips				Other:		
Sore throat tonsillitis				**MUSCULOSKELETAL**	**Now**	**Past**
Clears throat often				Swollen, painful or stiff joints		
Sore, red, or cracked tongue				Bone pains		
Cold sores or herpes				Painful feet, ankles or calves		
Inability to smell or taste				Tremors or twitches		
Excess cavities or bleeding gums				Loss of strength		
Hoarseness				Hernia		
Neck pain, stiffness, swelling				Muscle wasting		
Other:				Other:		
RESPIRATORY	**Now**	**Past**		**SKIN and HAIR**	**Now**	**Past**
Cough frequently				Acne or pimples		
Spitting up mucus or blood				Skin rashes or hives, skin ulcers or sores		
Difficulty breathing				Stretch marks		
Shortness of breath on exertion				Dryness, roughness or scaling skin, scalp, elbows, knees, feet, around nose, ears, eybrows etc		
Chest pain				Hair loss or thinning		
Other:				Dry, coarse hair or split ends		
CARDIOVASCULAR	**Now**	**Past**		Bruise easily		
Heart beats fast or irregular				Nails weak, ridged or split easily		
Tightness in chest				Brown spots or bronzing of skin		
Swollen hands or feet				Sunburn easily		
Hands or feet turns blue/fingernails turn blue				Cuts are slow to heal or scar badly		
Leg pains when walking				Burning feet		
Varicose veins				Athletes foot		

Tendency to anemia				Other:		
High/Low blood pressure				**FEMALE**	**Now**	**Past**
Other:				Irregular/regular menstruation		
DIGESTION/ABDOMEN	**Now**	**Past**		Pain prior to or with periods		
Heaviness after eating				Depressed, tense or irritable around periods		
Belching, gas or bloating, foul odor				Painful, swollen breasts		
Stomach or abdomen tender				Lumps in breasts, discharge from breasts		
Symptoms relieved /worse by eating				Pain, discomfort, discharge or itching in genital area		
Avoid certain food				Hot flashes		
Undigested food in stool				Diminished/excessive sex drive		
Headache, dizzy or irritable if skipping a meal				Difficulty having orgasm		
Diarrhea/loose stool, constipation				Inability to conceive		
Change in bowel movement				Other:		
Light colored or greasy stool				# of pregnancies:		
Feeling of incomplete evacuation				# of miscarriages/abortions:		
Hemorrhoids				**MALE**	**Now**	**Past**
Other:				Prostate problems		
URINARY	**Now**	**Past**		Difficulty or unusual urination		
Difficulty urinating, incomplete or dribbling				Discomfort or pain in genital area		
Urinate frequently at night/bedwetting				Diminished sex drive		
Pain when urinating				Excessive sex drive		
Bladder/Kidney infections				Difficulty maintaining erection		
Kidney stones/Low back pain				Other:		
Other:						

Patient Communication Authorization

Date: _____

Patient Name: _____

We must call on occasions to discuss confidential protected health information. Below is a list of ways for us to communicate this information with you. Please check how you would like us to get this information to you:

_____ Okay to call home and leave a message.

_____ Call my home phone but do not leave messages.

_____ Do not call home phone, call only this number: ( ) _____-_____

Can we leave a message at this number? _____yes _____no

_____ Do not speak to family members.

E-mail is sometimes convenient but some people have privacy concerns and e-mail delivery is not always reliable. My e-mail address for communication of protected health information is:

_____

_____ OK to e-mail request to contact office to above address.

_____ OK to reply to questions submitted from above address.

_____ OK to initiate e-mail to above address.

I give permission only to the following individuals listed below to receive protected health information:

_____

_____

This authorization can be revoked or modified by notifying us IN WRITING at any time.

Patient's Signature _____ Date_____

APPLICATION FOR EXAMINATION/TREATMENT

I. Patient Care

Please check the type of care desired;

Relief Care____ Corrective Care____ Doctor Recommended level of Care____

How did you find out about us? _____

II. Patient Information S.S.N.: _____-_____-_____ D.O.B.:_____

A. Personal Name _____
Gender: Male Female First Middle Last

Address: _____ City:_____ State:_____

Zip Code: _____ Home Phone:_____ Cell phone:_____

Email Address: _____

Are you: married, single, widowed, divorced, or separated

Children? names/ages?

_____

_____

B. Employment Occupation (describe)_____

Employed at: _____ Business phone: _____

Company Street & P.O. Box Address:_____

City: _____ State: _____ Zip Code: _____

C. Health Insurance Company: _____

Phone Number: _____ Policy Number: _____

III. Spouse Information: Name_____

S.S.N.:_____-____-_____ D.O.B.: _____ Home Phone: _____

Cell Phone: _____

Occupation (describe) _____ Company Name: _____

Company Address: _____ City:_____ St:_____

Zip Code: _____ Business Phone Number: _____

Ins. Company Name: _____ Policy Number:_____

IV. **Emergency Notification**

Closest friend or relative to contact in case of an emergency

Name: _____ D.O.B.: _____

Address: _____ City:_____ State:____

Home Phone: _____ Cell Phone: _____

V. **Finance and Authorization**

Fees are payable at the time of consultation, examination, laboratory, diagnostic imaging (x-ray), treatment or other services are performed. Exceptions must be made in advance. X-rays remain the property of this clinic. Copies will be made available on request and advance payment of copy fee.

Who will assist you in paying for your care?

No one____ Spouse____ Employer____ Insurance____ Other_____

How will payment be made?

Cash____ Check____ Credit Card____ Health Ins.____ Auto Ins.____ Other____

Patients Signature: _____ Date: _____

(Self/Legal Guardian)

Information Taken By: _____ Date: _____

(Office Staff)