Tula Wellness & Aesthetics

Medical Patient Intake Form

Please take your time filling out this questionnaire completely and honestly. This questionnaire will essentially address every area of daily life from how much you sleep to what you eat and your everyday stressors. You should commit at least one hour to complete this form. Information is acquired to evaluate your health profile from an integrative medicine perspective. However, it should also be the starting point for you to begin to see habits and exposures that prevent you from obtaining optimal health.

Patient Name *

First Name Last Name

Age *

Sex *

Date of Birth *

Month Day Year

Social Security Number *

For Insurance Purposes

Contact Information

Mobile Phone *

Please enter a valid phone number.

Home Phone

Please enter a valid phone number.

Email *

example@example.com

Address of the Primary Insured *

Street Address

Street Address Line 2

City | State / Province

Postal / Zip Code

Mailing Address (if different from above)

Street Address

Street Address

City | State

Zip Code

Pharmacy

Name of Preferred Pharmacy *

Pharmacy Cross Streets *

Pharmacy Phone Number

Please enter a valid phone number.

Current Medical Team

Primary Physician

PCP Phone Number

Please enter a valid phone number.

OB/GYN

OB/GYN Phone Number

Please enter a valid phone number.

Referred By

Emergency Contact

Name *

First Name Last Name

Relationship *

Phone Number *

Please enter a valid phone number.

Insurance

Tula Wellness & Aesthetics is only in-network with select plans. Please call your insurance to verify if we are in-network.

Name of Primary Insurance (if different than above) *

First Name Last Name

Relation to Insured *

Social Security Number of Primary Insured *

Date of Birth of Primary Insured *

Month Day Year

Name of Insurance Carrier *

Member ID# *

Group ID# *

Address from the back of your insurance card *

Street Address

Street Address Line 2

City

State / Province

Postal / Zip Code

Health History

What brings you to Tula Wellness? What concerns about your health do you have? *

What are your health goals? *

Medical Conditions

Please list the name and diagnosis date of any current medical conditions.

Please list the name and diagnosis date of any previous or childhood medical conditions.

Women's Health History

Date of last menstrual period

Month Day Year

Menses (check all that apply)

- ☐ Regular
- ☐ Irregular
- ☐ Painful PMS
- ☐ Other

If you checked "other" above, please describe:

Number of Children

Childrens' Ages

Age at start of periods

Age at end of periods/menopause

History of abnormal pap smears?

If Yes, please explain follow-up and treatment you received.

History of breast surgery?

If Yes, please explain.

History of hysterectomy or pelvic surgery?

If Yes, please explain.

Hormone Replacement Therapy

Have you ever used hormone replacement therapy?

If yes, list medications, dose, directions and the duration of the treatment.

Did you have any problems? If yes, please explain.

Diagnostic Studies

Date of last mammogram:

Month Day Year

Mammogram Results:

Date of last pap smear:

Month Day Year

Pap smear results:

Have you ever had additional diagnostic studies? *

Yes (please provide information below) No

Last Date Done & Results (-/+)

Please list a date and positive or negative (+/-) for any applicable diagnostic studies below.

Colonoscopy

Year

Result

- -
- +

Bone Density

Year

Result

- -
- +

Electrocardiogram

Year

Result

- -
- +

Other (specify below)

Testing:

Year

Result

- -
- +

Surgeries & Hospitalizations

Procedure & Date

Procedure & Date

Procedure & Date

Allergies

Do you have an ALLERGY to a drug or other substance? *

If yes, please describe all.

Current Prescription Medications

Drug Name(s), Strength(s), Dosage(s). If none, please write NONE. *

Supplements and Over-The-Counter

Drug Name(s), Strength(s), Dosage(s). If none, please write NONE. *

Family Health History

Please tell me about your family. Please include any family member with a history of tuberculosis, diabetes, cancer, emphysema, kidney disease, ulcer, nervous breakdown or gall bladder disease.

Mother:

Health Status

Age (if alive):

Age at Death (if deceased):

Cause of Death:

Health Problem (if any):

Father:

Health Status

Age (if alive):

Age at Death (if deceased):

Cause of Death:

Health Problem (if any):

Relationship:

Health Status

Age (if alive):

Age at Death (if deceased):

Cause of Death:

Health Problem (if any):

Relationship:

Health Status

Age (if alive):

Age at Death (if deceased):

Cause of Death:

Health Problem (if any):

Additional information related to your Family Medical History you would like me to know:

Social and Socioeconomic History

Occupation:

Employer:

Highest Degree Earned:

Do you enjoy your job?

Why? / Why not?

Present Marital Status: *

Spouse/Partner's Name:

Total # in household, including your children? *

What are your main interests and hobbies?

Habits & Lifestyle

Alcohol Use *

- ○ Yes
- ○ No

If yes, what kind?

If yes, how many per week?

Tobacco Use *

- ○ Yes
- ○ No

If yes, what kind?

If yes, how many per week?

Recreational Drug Use *

- ○ Yes
- ○ No

If yes, what kind?

If yes, how many per week?

Have you ever felt that you ought to cut down on your drinking or drug use? *

Do you get annoyed at criticism of your drinking or drug use? *

Do you ever feel guilty about your drinking or drug use? *

Do you ever drink for an early morning "eye opener"? *

Do you feel safe in your surroundings? *

Do you have a history of sexual abuse? *

Sexual Activity

Sexual Orientation

Are you sexually active?

Birth Control Method?

Sexually Transmitted Infections?

Do you practice safe sex?

Men's Health History

Have you had any of the following procedures/exams? If yes, what was the date/result?

PSA?

Prostate Exam?

Vasectomy?

Sexually transmitted infections?

Cardiovascular Health:

Do you use Nitrates for chest pain?

- ○ No
- ○ Yes

Sexual Dysfunction

Do you have trouble starting or maintaining an erection?

If yes, have you used any medications for it? If so, what did you use?

Did it help? If no, please explain.

Do you have a family history of any of the following?

Prostate Cancer?

Testicular Cancer?

Average hours per night of sleep: *

Average hours per day of television: *

Average hours per day of reading: *

What do you do to relax/recreate/socialize/cope with stress? *

What are the major stressors in your life? *

When are you happiest? What gives you joy? *

Describe your energy level throughout a typical day rating on a scale of 1-10: 1=Extreme Fatigue 10=Feeling Great and Energized

	1-10
Early Morning	
Mid Morning to Noon	
Mid Afternoon	
Evening	

Please describe any associated food or drink cravings (sugar, coffee, cola, etc): *

Please check any practices you have tried:

- ☐ Acupuncture
- ☐ Nutritional Medicine
- ☐ Naturopathic Medicine
- ☐ Chelation Therapy
- ☐ Hypnosis
- ☐ Meditation
- ☐ Fasting
- ☐ Herbal Medicine
- ☐ Neuro-Linguistic Programming
- ☐ Light Therapy
- ☐ Traditional Chinese Medicine
- ☐ Environmental Medicine
- ☐ Yoga
- ☐ Ayurvedic Medicine
- ☐ Orthomolecular Biofeedback
- ☐ Guided Imagery
- ☐ Aromatherapy
- ☐ Bodywork
- ☐

If you checked "other," please describe:

Emotional Well Being

How well have things been going for you at school? *

How well have things been going with close friends? *

How well have things been going for you with your children? *

How well have things been going for you at your job? *

How well have things been going for you with sex? *

How well have things been going for you with your parents? *

How well have things been going for you with your social life? *

How well have things been going for your attitude *

How well have things been going for you with your spouse/partner? *

Nutrition Evaluation

Please list all foods and drinks you have consumed in the past 24 hours. Include meals, snacks, beverages and condiments.

Food items; How prepared (baked, fried, etc); Amount (cups, ounces, etc): *

Is this a typical day? *

- No
- Yes

Are you currently on a special diet? *

- No
- Yes

If yes, please describe:

Do you have symptoms immediately after eating such as bloating, sneezing, hives, etc.? *

- ○ No
- ○ Yes

If yes, are these symptoms associated with any particular food or supplement(s)? *

- ○ No
- ○ Yes

Please name the food or supplement and the symptom(s); e.i. Milk = gas, diarrhea

Do you feel you have delayed symptoms after eating certain foods? (symptoms may not be evident for 24 hours or more) Symptoms include: fatigue, muscle aches, sinus, congestion, etc. *

- ○ No
- ○ Yes

Review of Systems

Please check any current symptoms you may have:

Constitutional

- ☐ Recent Fever
- ☐ Night Sweats
- ☐ Hot Flashes
- ☐ Unexplained Weight Loss/Gain
- ☐ Decline in Libido

Cardiovascular

- ☐ Chest Pains/Discomfort
- ☐ Palpitations
- ☐ Short of breath with Exertion

Respiratory

- ☐ Cough/Wheeze

- [ ] Coughing up Blood

Sexual Function

- [ ] Pain with Intercourse
- [ ] Vaginal Dryness
- [ ] Decrease Sexual Desire
- [ ] Inability to Orgasm
- [ ]

Genitourinary

- [ ] Painful/Bloody Urination
- [ ] Leaking Urine
- [ ] Nighttime Urination
- [ ] Unusual Vaginal Bleeding
- [ ] Frequent Urination

Skin

- [ ] Rash
- [ ] New or Change in Mole
- [ ] Thin, Ridged, Splitting or Crumbling Nails

Psychiatric

- [ ] Anxiety/Stress
- [ ] Sleep Problems
- [ ] Depression
- [ ] Irritability

Eyes

- [ ] Changes in Vision

Gastrointestinal

- [ ] Heartburn/Reflux
- [ ] Blood or Change in Bowel Movement
- [ ] Nausea/Vomiting/Diarrhea/Constipation
- [ ] Pain in Abdomen/Plevis
- [ ] Irritable Bowel Syndrome/Digestive Problems
- [ ] Fecal Incontinence

Blood/Lymphatic

- [ ] Unexplained Lumps
- [ ] Easy Bruising/Bleeding

Neurological

- [ ] Heaches
- [ ] Memory Loss
- [ ] Fainting

Ear/Nose/Throat

- [ ] Difficulty Health
- [ ] Hay Fever/Allergies
- [ ] Trouble Swallowing

Musculoskeletal

- [ ] Muscle/Joint Pain
- [ ] Recent Back Pain

Endocrine

- [ ] Cold/Heat Intolerance
- [ ] Increased Thirst/Appetite