Intake Questionnaire

Please Print

Date:	How did you hear about our practice? Facebook, Radio Ad, Google Ad, Personal Referral by:	
Name:		
Home Address:	City: State: ZIP:	
E-Mail Address:		
Home Phone:	Cell:	Work:
Sex: Male Female	Age:	Birth Date:
Height:	Weight:	Desired Weight:
Marital Status: Married Divorced Widow	Number of children & ages:	
Pharmacy:	Phone: Fax:	
Social History	Occupation:	Employer:
Do you smoke:	How much:	Quit:
Alcohol consumption per week & type:		
Surgical History	Please list all surgeries:	
Medical History	Please list any prior diagnosis:	
Primary reason you came for evaluation		
Allergies to Medications		
Allergies to Food		
Allergies: Environment:		

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

Supplements & Vitamins	Dose	Frequency	Reason Why
Medications (prescriptions)	Dose	Frequency	Reason why
Family Medical History			

Cancer: (what type & who)		
Hypertension	Heart Disease	Osteoporosis
Diabetes	Stroke	Other

Antibiotic History: Have you ever taken repeated courses of antibiotics as a child for ear, throat, or respiratory infections, as a teen for acne, or as an adult for any significant infections? If so, offer brief detail.

Exercise: Do you exercise regularly? If not, briefly state what is limiting you from doing so.

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

Nutritional Assessment
What are your nutritional goals or desires?
Are you happy with your present weight? Wish to gain or lose weight?
Food dislikes: please list foods that you do not like to eat.
Do you suspect you have any food sensitivities or allergies?
Do you experience signs or symptoms of low blood sugar? (drop in energy, fuzzy headed, shaky, need frequent meals)
If one serving of vegetable is represented as ½ cup of cooked vegetable or 1 cup of raw vegetable, how many servings of vegetable do you eat daily on average?
Fish: servings per week? What type of fish?
How many fruit servings do you eat daily?
How much water, just plain water (not juice, pop, tea, or other liquid) do you drink on a daily basis? Express this in ounces if possible.
How often do you eat out at restaurants?
What is your typical day's food and beverage intake? List food and beverage serving size.
Breakfast:
Lunch:
Dinner:
Snacks:
Soft drink consumption, type and amount:

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

EMERGENCY CONTACT **Name:**	**Phone:**
Current Health Care Providers	
Name & Specialty:	
Address:	
Phone #:	FAX:
Name & Specialty:	
Address:	
Phone #:	FAX:
Name & Specialty:	
Address:	
Phone #:	FAX:

Please Rate Yourself
Rate what you feel is your current level of health? 1 = very poor 10 = outstanding
Rate current level of mental health, mood, joy, contentment: 1= very poor 10 = outstanding

Please bring a copy of the most ***recent*** lab results or procedural reports **(*done in the past year*).**

Bring any ***recent*** medical records that you feel may impact your care with us. Any DEXA bone density scans, CT's, MRI's, Ultrasounds, X-Rays, Colonoscopy, or other tests.

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
GASTROINTESTINAL SYSTEM					
I have gas, bloating, or general discomfort after eating.	0	1	2	3	4
I have a general, hard to describe, discomfort in the abdomen	0	1	2	3	4
I experience heartburn, acid reflux, or take acid blocker medication.	0	1	2	3	4
I have constipation defined as less than one soft bowel movement daily.	0	1	2	3	4
I have watery stool more often than twice a year.	0	1	2	3	4
I alternate between diarrhea and constipation	0	1	2	3	4
I experience seasonal allergies, or ear, nose and throat problems.	0	1	2	3	4
I have recurrent sinus fullness or sinus infections	0	1	2	3	4
I have recurrent athlete's foot, fungal toenails, or other unexplained skin rash	0	1	2	3	4
I have noticed a white coating or plaque on my tongue	0	1	2	3	4
I have had recurrent vaginal yeast,	0	1	2	3	4
I have a history of IBS, Crohn's, Ulcerative colitis or other inflammatory issue	0	1	2	3	4
My stool appears black or looks like tar	0	1	2	3	4
I see mucous in my stool	0	1	2	3	4
I see blood in my stool or on the toilet paper	0	1	2	3	4
I have pain on the right side of abdomen under the rib cage	0	1	2	3	4
Use of NSAID medication such as Advil, Ibuprofen, Aleve, Naprosyn, etc.	0	1	2	3	4
IMMUNE & ALLERGY					
I experience runny nose, congestion or drainage in throat	0	1	2	3	4
Sinus fullness or infection	0	1	2	3	4
Frequent ear and or throat infections	0	1	2	3	4
Chronic swollen lymph glands	0	1	2	3	4
Loss of smell or loss of taste	0	1	2	3	4
Catch colds and flu easily and slow to recover	0	1	2	3	4
I have bumpy skin on the back of my arms	0	1	2	3	4
Wheezing or chronic lung congestion	0	1	2	3	4
Skin rashes	0	1	2	3	4
Certain foods make me sick or nauseated, depressed or jittery	0	1	2	3	4

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
ENDOCRINE					
I experience a drop in energy or feelings of exhaustion in the early afternoon	0	1	2	3	4
I have excessive stress in my life on a daily basis	0	1	2	3	4
I feel "on edge" throughout the day, or a feeling of being overwhelmed	0	1	2	3	4
I experience strong carbohydrate or sugar cravings	0	1	2	3	4
I drink 4 or more cups of coffee daily (one cup of coffee = 6 ounces)	0	1	2	3	4
I have dark circles under my eyes	0	1	2	3	4
Poor memory or mental focus. Trouble making decisions.	0	1	2	3	4
I feel emotionally "flat". Less ability to feel joy.	0	1	2	3	4
Poor recovery from injury or illness	0	1	2	3	4
Decreased stamina or exercise tolerance	0	1	2	3	4
Feelings of apathy or depression	0	1	2	3	4
Feel dizzy upon rising from a seated or lying position	0	1	2	3	4
ENDO - Thyr					
Feel "creaky" or stiff. Especially in the morning or after sitting for a while.	0	1	2	3	4
Muscles feel achy or are sore to touch	0	1	2	3	4
Slow to start in the morning. Takes more than an hour to feel awake, normal.	0	1	2	3	4
Dizzy or nauseated in the morning.	0	1	2	3	4
Dry skin, dry hair, brittle hair, brittle fingernails, cracking nails.	0	1	2	3	4
Thinning of the lateral or outer part of the eyebrow	0	1	2	3	4
Mental fog or difficulty concentrating	0	1	2	3	4
Tend to have cold hand and cold feet	0	1	2	3	4
Depression or low mood. Emotionally feel "flat"	0	1	2	3	4
Gaining weight easily	0	1	2	3	4
ENDO - Ins					
I feel the need to eat every 2 to 3 hours or I will feel poorly and lose energy	0	1	2	3	4
Irritable if I miss a meal	0	1	2	3	4
I crave sweets and carbohydrates (bread)	0	1	2	3	4
I awaken in the middle of the night craving sweets	0	1	2	3	4
Poor memory or poor concentration	0	1	2	3	4
I feel an increased thirst	0	1	2	3	4
Wounds seem to take a long time to heal	0	1	2	3	4
I am overweight	0	1	2	3	4

I have a family history of diabetes	0	1	2	3	4

Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
CARDIOVASCULAR					
Heart has missed beats or extra beats. Heart feels irregular	0	1	2	3	4
My heart pounds heavily, or I have palpitations at times	0	1	2	3	4
Heaviness in legs or muscle cramps while walking	0	1	2	3	4
Swelling or puffiness to feet and ankles	0	1	2	3	4
Varicose veins	0	1	2	3	4
I have loss of hair on the lower leg	0	1	2	3	4
I have experienced slurred speech	0	1	2	3	4
Experience dizziness or vertigo	0	1	2	3	4
My blood pressure is/has been high	0	1	2	3	4
My cholesterol is/has been high	0	1	2	3	4
RESP					
I have a chronic cough	0	1	2	3	4
I cough up blood or phlegm	0	1	2	3	4
I experience shortness of breath	0	1	2	3	4
I experience a wheeze	0	1	2	3	4
I smoke tobacco products – cigarettes, cigars, etc.	0	1	2	3	4
I experience chronic recurrent bronchitis	0	1	2	3	4
NEURO					
Loss of feeling in hands or feet	0	1	2	3	4
Tingling sensation or lack of feeling (numb)	0	1	2	3	4
Light headedness or fainting	0	1	2	3	4
Weakness to one or more extremities	0	1	2	3	4
Loss of balance, dizziness, or vertigo	0	1	2	3	4
Poor cognition, poor memory, reduced ability to solve problems	0	1	2	3	4
Poor mental focus or concentration	0	1	2	3	4
Nervous, anxious, or easily agitated	0	1	2	3	4
I get headaches frequently or even daily	0	1	2	3	4
I have a history of shingles	0	1	2	3	4
I get recurrent cold sores to my mouth or lip area	0	1	2	3	4

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to "intensity" use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
SLEEP CYCLE					
I can't fall asleep easily, I lay in bed more than 15 minutes before I can sleep	0	1	2	3	4
I sleep less than 7 hours per night.	0	1	2	3	4
My sleep is interrupted. I awaken to urinate or for no reason at all.	0	1	2	3	4
If I awaken thru the night I have trouble falling back to sleep	0	1	2	3	4
I do not feel refreshed in the morning after awakening.	0	1	2	3	4
I feel like my brain won't shut off, it's constantly busy thinking at night.	0	1	2	3	4
I have restless legs or leg cramps at night	0	1	2	3	4
**** Circle ONE answer**- I sleep <4 hours 4 – 5 hours 5 – 6 hours 6 – 7 hours more than 7 hours					
MUSCULOSKELATAL					
Bursitis, tendonitis, or other joint pain from soft tissue	0	1	2	3	4
Joint pain or osteoarthritis – related to the bone	0	1	2	3	4
History of rheumatoid arthritis	0	1	2	3	4
Low back pain or disc disease, degenerative spine or disc problems	0	1	2	3	4
Neck or cervical pain	0	1	2	3	4
Muscle spasm or cramps	0	1	2	3	4
Bone loss – osteoporosis or osteopenia	0	1	2	3	4

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com

FEMALE - Urogenital					
Stress incontinence – accidentally spill urine when you cough, sneeze or laugh	0	1	2	3	4
Pain or burning with urination or frequent need to urinate	0	1	2	3	4
I have a history of frequent kidney, bladder, or urinary tract infections	0	1	2	3	4
Urine appears odd – strong smell, cloudy, bloody	0	1	2	3	4
Tender breasts – either intermittently or related to menstrual cycle	0	1	2	3	4
PMS – moody or irritable around menstrual cycle	0	1	2	3	4
Headaches related to menstrual cycle	0	1	2	3	4
Recurrent vaginal yeast infections or vaginal itching	0	1	2	3	4
Low sex drive	0	1	2	3	4
Uncomfortable intercourse secondary to vaginal dryness	0	1	2	3	4
Diagnosed with uterine fibroids – benign uterine masses	0	1	2	3	4
History of an abnormal PAP smear	0	1	2	3	4
I have fibrocystic breast disease – lumps or bumps noted in breast tissue	0	1	2	3	4
I have a history of using birth control pills – short or long term	0	1	2	3	4
Hot flashes or “power surges”	0	1	2	3	4
Night sweats	0	1	2	3	4
I had difficulty getting pregnant or required fertility treatments	0	1	2	3	4
I have a history of genital herpes	0	1	2	3	4
Score: 0 = Never 1 = Rare 2 = Occasional 3 = Most of the time 4 = Always Or if the question relates to “intensity” use this same 0 – 4 scale as the following: 0 = None 1 = Mild 2 = Moderate 3 = Moderately severe 4 = Severe					
MALE - Urogenital					
I have a history if swollen prostate or benign prostatic hypertrophy	0	1	2	3	4
History of prostate infection – prostatitis	0	1	2	3	4
Slow in initiating urinary stream	0	1	2	3	4
Reduced flow or force of urinary stream	0	1	2	3	4
Frequent need to urinate	0	1	2	3	4
Awaken in the night to urinate	0	1	2	3	4
Erectile dysfunction – incomplete erections	0	1	2	3	4
Loss of sex drive	0	1	2	3	4
I have a history of herpes	0	1	2	3	4
Urinary tract infections	0	1	2	3	4

8170 Corporate Park Drive, Suite 150, Cincinnati, Ohio 45242 Phone: 513-924-5300 Fax: 513-351-3800
www.huberpm.com