

Patient Intake Form

Name _____

Date _____

DOB _____

Age _____

Phone _____

Address _____

Email _____

Please describe the reason(s) for wanting to work with Dr. Lucille:

Please share what you would like to change about your health and wellness:

Please describe any past health issues, hospitalizations or illnesses:

Please list and describe all family medical history:

Please list:

Other practitioners seen or seeing

Specific treatment/testing done
(Include results if available)

Any medication you are currently taking: dosage, how long and reason prescribed

Any supplements you are currently taking, brand, dosage, and for what reason

Please share aspects of you life:

SLEEP

How many hours per night do you sleep? _____

What is the quality of your sleep _____

Do you have trouble falling asleep? Y N

Do you have trouble staying asleep? Y N

Do you wake feeling rested? Y N

ENERGY

Describe you energy throughout the day _____

Do you ever "borrow" energy from caffeine or sugar during the day? Y N

Do you fell calm at the end of your day? Y N

STRESS

Please describe the role stress play in your life, both historically and currently

Have you ever had periods of extreme and chronic stress? Y N

If yes, please

explain _____

How do you feel you handle stress?

Explain how you cope with stress

SOCIAL HISTORY

Do you have supportive relationships in your life?	Y	N
Do you use alcohol? If so, what do you drink and how often?	Y	N
Do you use caffeine? If so, what and how often?	Y	N
Do you use or have you ever used drugs?	Y	N
Do you use tobacco products? If so, how often and how long?	Y	N

DIET

Please use the space below to describe what your relationship with food has been like over your lifetime, up to the present. Then, provide a 24-hour recall of what you have eaten and drank, including portions and times.

Thank you, so much for sharing, is there anything else you would like Dr. Lucille to know?

_____Signature _____Date