Dr. Samadi's Health & Wellness Institute

New Patient Intake Form

Reason for Visit:

Please describe the reason for today's visit:

_____

_____

Top Three Health Goals

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1. _____
2. _____
3. _____

Physical Dimensions

Current height ____feet ____inches

What was your height when you were in your early 20s? _____

Current weight (lbs.) _____

Ideal weight (lbs.) _____

Body frame XS S M L XL XXL

Body type Masculine Feminine Androgynous

Symptoms:

Energy and Weight (Constitutional)

Rank from 0 (none/never) to 5 (always/severe)

Unexplained weight loss
Weight gain - all over
Weight gain - belly/midsection
Weight gain - butt/hips/thighs
Change in appetite
Fatigue, malaise, lethargy
Morning fatigue
Afternoon fatigue
Evening fatigue

Fatigue - worsens if you miss a meal
Fatigue - worsens after eating carbohydrates
Frequent fever or chills

Eyes & Vision (Eyes)
Rank from 0 (none/never) to 5 (always/severe)
Swelling around eyes/puffy eyes
Visual changes
Frequent double or blurred vision
Eye pain
Frequently appears as if a shade were being pulled over either eye

Ears/Nose/Mouth/Throat
Rank from 0 (none/never) to 5 (always/severe)
Frequent stuffy ears
Ear pain
Ringing in ears
Hearing loss
Frequent runny nose
Frequent nose bleeds
Sinus pain/infection
Frequent bleeding gums
Toothache
Frequent sore throat
Pain with swallowing
Frequent trouble swallowing
Pain with opening/closing your mouth, chewing, etc.
Hoarseness

Breathing (Respiratory)
Rank from 0 (none/never) to 5 (always/severe)
Frequent wheezing
Frequent coughing
Shortness of breath with minimal exercise
Shortness of breath while lying flat

Heart (Cardiovascular)
Rank from 0 (none/never) to 5 (always/severe)
Chest pain at rest
Chest pain with exertion
Frequent irregular heartbeat
Ankles swell significantly with standing or walking for a long time
Calves burn if you walk more than a short distance
Frequent palpitations/heart skipping

Digestion (Gastrointestinal)

Rank from 0 (none/never) to 5 (always/severe)

Frequent heartburn
Burning in your stomach if you haven't eaten for a while
Nausea or the feeling that you may vomit
Vomiting
Vomiting of blood or vomit that resembles coffee grounds
Sense of being full before eating much of a meal
Frequent bloating after eating
Abdominal pain/cramping
Change in bowel habits
Frequent constipation
Frequent loose stools
Frequent mucus in stool
Frequent undigested food in stool
Frequent gas/flatulence/burping
Frequent blood in your stools
Hemorrhoids

Hormonal (Endocrine)

Rank from 0 (none/never) to 5 (always/severe)

Cold hands and feet
Body temperature below normal
Sensitivity to cold
Difficulty tolerating hot environments
Difficulty tolerating cold environments
Increased sweating
Decreased sweating
Lack of sweating
Increased hunger
Increased thirst
Sugar cravings
Salt cravings
Frequent poor appetite
Night sweats
Hot flushes/sweating
Water retention

Kidney (Genitourinary)

Rank from 0 (none/never) to 5 (always/severe)

Frequent blood in urine
Urinate more than 5 times per day
Urinate more than 2 times per night
Difficulty in starting to urinate
Dribbling after you have stopped urinating
After you urinate, you feel as though you still have to urinate more?

Decreased force of stream
Incontinence with exercise or coughing
Pain/burning with urination
Frequent bladder infections
Bladder problems/incontinence
Frequent urination
Erectile Dysfunction (ED)

Menses& Vagina (Gynecologic)

Rank from 0 (none/never) to 5 (always/severe)

Having periods
Regular periods
Irregular periods
Heavy periods
Scant or light periods
Spotting between periods
Painful periods
Vaginal pain
Dryness of vagina
Vaginal discharge/odor
Sores (lesions) on labia
Frequent vaginal infections

Brain and Nerves (Neurologic)

Rank from 0 (none/never) to 5 (always/severe)

Tingling of hands or feet
Frequent weakness in an arm or a leg
Vertigo or the sensation of the room spinning
Headaches
Get dizzy if you turn your head quickly
Frequent lightheadedness
Frequent drowsiness
Frequent difficulty talking distinctly
Tremor or shaking of your hands
Increased difficulty with memory
Frequent fainting
Numbness in hands or feet
Loss of balance
Clumsiness or lack of coordination

Mood (Psychiatric)

Rank from 0 (none/never) to 5 (always/severe)

Foggy thinking/brain fog
Mental exhaustion
Trouble concentrating
Frequently forgetful

Mood swings
Little interest or pleasure in doing things
Decreased satisfaction at work
Deterioration in work performance
Frequent panic attacks
Frequently fearful
Frequently irritable
Frequently anxious
Stress
Frequently aggressive
Frequently sad/tearful
Depressive moods
Moving/speaking slowly or fidgety/restless
Feeling bad about yourself
Thoughts of suicide/better off dead

Joint and Bone Problems

Rank from 0 (none/never) to 5 (always/severe)

Swelling of your joints
Aching/painful joints
Back pain
Neck pain
Aching/painful muscles
Frequent stiff muscles and joints in the morning
Loss in height
Muscle cramps or spasms
Decreased stamina/endurance
Decreased physical strength
Decreased muscle size
Less effective workouts
Decreased athletic ability
Physical exhaustion

Skin/Hair

Rank from 0 (none/never) to 5 (always/severe)

Acne
Thinning skin
Dry scaly skin
Oily skin and/or hair
Itching
Rash/rashes
Discolored areas of skin
Growths on skin
Changes in size or color of moles
Bumps on back of upper arms

Frequent dark circles under eyes
Nails breaking or brittle
Fungus - fingers
Fungus - toes
Nail ridges
Changes in hair or skin texture
Loss of scalp hair
Increased facial and body hair
Decreased facial hair
Hair dry or brittle

Breasts

Rank from 0 (none/never) to 5 (always/severe)
Increase in breast size
Breast cysts/lumps
Frequent breast pain/tenderness
Frequent discharge from breast

Bleeding (Hematologic/Lymphatic)

Rank from 0 (none/never) to 5 (always/severe)
Excessive or easy bruising
Frequent prolonged or excessive bleeding
Enlarged lymph nodes

Allergic/Immunologic

Rank from 0 (none/never) to 5 (always/severe)
Frequent recurrent infections
Sensitivities to chemicals
Allergies: Hypersensitivity to medications, foods, environments, etc.

Sexual

Rank from 0 (none/never) to 5 (always/severe)
Libido (desire to have sex) is diminished
Libido (desire to have sex) is too high
Difficulty with arousal
Decreased orgasms
Painful intercourse

Other Concerns

Do you have additional / specific concerns that you would like to discuss with the provider?

_____

_____

_____

Nutrition & Diet

Food Diary

Date: _____

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Date: _____

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Date: _____

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Diet

Do you currently follow a special diet or nutrition plan? Yes No
Mixed (animal and vegetable sources) Yes No
Physician-assisted low calorie diet (HCG, Medi-Fast, etc.) _____

Commercial diet plan (Weight Watchers, Jenny Craig, etc.) _____

Starch/carbohydrate restriction (Atkins type) _____

Allergy restricted (gluten free/dairy free) _____

High protein (Paleo type) _____

Vegetarian/vegan _____

Nutrition

Do you dislike healthy food? Yes No
Are you an emotional eater? Yes No
Do you overeat under stress? Yes No
Do you eat too little under stress? Yes No
Do you eat mostly non-organic foods? Yes No
Do you drink at least 8 glasses of water a day? Yes No
Do you use caffeine (coffee, tea, soda, energy drinks, etc.)? Yes No
How many servings per day?
More than 32 oz per day
16 to 32 oz per day
Less than 16 oz per day
Do you take antacids anti-GERD meds frequently? Yes No
Do you take lactose intolerance pills frequently? Yes No

Exercise:

Type of Workout

Cardio/aerobic
Select... 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Strength training
Select... 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Other (Yoga, pilates)
Select... 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%
Walking
Select... 0% 10% 20% 30% 40% 50% 60% 70% 80% 90% 100%

Workout Details

Average number of workouts per week
Select... 0 1 2 3 4 5 6 7 8 9 10+
Average time per workout
Select... No Workouts 0-30 31-45 46-60 60+
Average intensity of workout
Select... No Workouts Light Moderate Hard Very Hard
Do you feel unusually fatigued after exercise?

Job Intensity

Job intensity: Select: Sedentary Non SedentaryPhysical

Energy & Sleep:

Energy Level

Rank from 1 (low) to 5 (high) _____

Sleep Pattern

Length of time to fall asleep (minutes) _____
Hours slept before waking for first time (hours) _____
Average hours slept each night (hours) _____

Sleep Problems

Do you snore?	Yes	No
Do you wake with a headache?	Yes	No
Do you wake up feeling tired/not rested?	Yes	No
Do you have trouble falling asleep?	Yes	No
Do you wake up often throughout the night?	Yes	No
Do you have trouble falling back to sleep once awakened?	Yes	No
Do you use a sleep apnea device?	Yes	No
Do you take herbal or over-the-counter medication to sleep?	Yes	No
Do you take prescription medication to sleep?	Yes	No
Have you been told that you stop breathing while asleep?	Yes	No
Do you kick or jerk your legs and/or arms while asleep?	Yes	No
Do you ever awake choking, gasping for air, or feeling smothered?	Yes	No
Do you experience restlessness, tingling, or crawling in your arms or legs?	Yes	No
Do you experience inability to keep your legs still prior to falling asleep?	Yes	No
As an adult, have you had episodes of talking in your sleep?	Yes	No
As an adult, have you had episodes of sleep walking?	Yes	No
Does your heart pound at night?	Yes	No

Stress:

Stressors

Rank from 1 (none/never) to 5 (always/severe)

Do your children cause you stress?	Yes	No
Does your spouse/significant other cause you stress?	Yes	No
Do financial concerns cause you stress?	Yes	No
Does your job cause you stress?	Yes	No
Do you feel you have an excessive amount of stress in your life?	Yes	No
Do you handle stress poorly?	Yes	No
Have you ever been abused, a victim of a crime, or had a significant trauma?	Yes	No
Have you experienced major losses in your life?	Yes	No
Other Stressors (list the things that cause you stress)	Yes	No

Add Stressor _____

Stress Management	
Do you pray?	Yes No
Do you pray or meditate?	Yes No
Do you exercise?	Yes No
Do you get enough sleep?	Yes No
Do you feel that you have a good social support structure?	Yes No
Stress relievers (list things that you do to relieve your stress)	_____

Allergies:

Environmental Allergies	
Aerosol (cologne, smoke, cleaning fluids)	Yes No
Seasonal (ragweed, pollen, dust)	Yes No
Pet/animal (dogs, cats, etc.)	Yes No
Latex (gloves, tape)	Yes No
Food Allergies	
Grain (corn, wheat, rye, barley, spelt, etc.)	Yes No
Gluten	Yes No
Dairy/lactose	Yes No
Nuts (peanuts, Brazil nuts, walnuts, etc.)	Yes No
Shellfish (shrimp, lobster, crab)	Yes No
Soy	Yes No
Eggs	Yes No
Yeast	Yes No
Caffeine	Yes No
Food preservatives (sodium benzoate, MSG, sulfites, etc.)	Yes No

Exposure	
In your work or home environment, are you or have you been exposed to the following?	
Radiation	Yes No
Radon	Yes No
Second-hand smoke	Yes No
Asbestos	Yes No
Lead	Yes No
Mercury	Yes No
Coal	Yes No
Electronics (power lines, Wi-Fi, cell phone, EMF, etc.)	Yes No
Toxic chemicals (e.g. dry cleaning fluid, solvents, pesticides)	Yes No
Mold	Yes No

Meds & Supplements (please bring a list of your OTC meds and Supplements to the office, including the dosage and the frequency of taking them)

Over-the-Counter Medications Name:

_____

Vitamins & Supplements Name

Have you had prolonged or regular use of NSAIDs? Yes No
Have you had prolonged or regular use of antibiotics? Yes No
Have you had prolonged or regular use of steroids? Yes No

Tests & Procedures

Have you ever had a bone density/scan? Yes No
Date: _____
Results Normal Abnormal

Have you ever had a mammogram? Yes No NA
Date: _____
Results Normal Abnormal

Have you ever had a breast exam using thermography? Yes No NA
Date: _____
Results Normal Abnormal

Have you ever had a colonoscopy? Yes No
Date: _____
Results Normal Abnormal

Have you ever had a cardiac stress test? Yes No
Date: _____
Results Normal Abnormal

Have you ever had a calcium coronary scan/test? Yes No
Date: _____
Results Normal Abnormal

Have you ever had a carotid artery ultrasound? Yes No
Date: _____
Results Normal Abnormal

Have you ever been tested for glaucoma? Yes No
Date: _____
Results Normal Abnormal

Have you ever had a skin exam? Yes No
Date: _____
Results Normal Abnormal

Have you ever had a uterine ultrasound? Yes No NA
Date: _____
Results Normal Abnormal

Have you ever had a Pap smear? Yes No NA
Date: _____
Results Normal Abnormal

Have you ever had a prostate examination done? Yes No NA
Date: _____
Results Normal Abnormal

Have you ever had a PSA blood test done? Yes No NA
Date: _____
Results Normal Abnormal

Medical History: (please circle)

Respiratory
Don't Know
Asthma
Chronic bronchitis
Emphysema (COPD)
Pulmonary hypertension
Chronic sinusitis
Pneumonia
Sleep apnea
Tuberculosis

Blood Pressure
Don't Know
High blood pressure
Low blood pressure

Bleeding Problems
Don't Know
Blood clots
Hemophilia
Factor V Leiden

Cardiovascular

Don't Know

Coronary artery disease
Heart attack
Congestive heart failure
Carotid artery stenosis
Arrhythmia

Cholesterol Problems

Don't Know

High cholesterol
High triglycerides

Gastrointestinal

Don't Know

Reflux (heartburn)
Stomach ulcers
Gall bladder disease
Liver disease
Inflammatory bowel disease
Crohn's disease
Ulcerative colitis
Celiac disease

Blood Sugar Problems

Don't Know

Diabetes (onset as adult, treated with medication)

Weight Problems

Don't Know

Obesity Year:_____
Overweight Year:_____
Underweight Year:_____
Anorexia Year:_____
Bulimia Year:_____

Thyroid Problems

Don't Know

Low thyroid (hypothyroidism) Year:_____
Hashimoto's thyroiditis Year:_____
High thyroid (hyperthyroidism) Year:_____
Thyroid nodules Year:_____
Graves disease Year:_____
Goiter (enlarged thyroid) Year:_____

Neurological History

Stroke Year:_____
ADD/ADHD Year:_____
Brain injury/concussion Year:_____

History of Mental Illness

Depression Year:_____
History of suicide attempts Year:_____
Anger management problem Year:_____
Bipolar disorder Year:_____
Post-traumatic stress disorder Year:_____
Schizophrenia Year:_____

Joint and Bone Problems

Arthritis
Rheumatoid arthritis
Gout (arthritis)
Osteopenia (weakening bones)
Osteoporosis (weak bones)

Immune System

Don't Know

HIV
Hepatitis
Herpes
Mononucleosis
Epstein-Barr virus (EBV)
Multiple sclerosis
Lupus SLE
Cytomegaly Virus (CMV)
Covid-19 Year:_____

Energy Problem

Don't Know

Chronic fatigue syndrome Year:_____
Fibromyalgia Year:_____

Cancer History

Don't Know

Breast cancer Year:_____
Uterine cancer Year:_____
Cervical cancer Year:_____
Esophagus cancer Year:_____
Stomach cancer Year:_____
Colon cancer Year:_____
Ovarian cancer Year:_____

Skin cancer Year:_____
Lung cancer Year:_____
Bladder cancer Year:_____
Kidney cancer Year:_____
Testicular caner Year:_____
Prostate cancer Year:_____
Thyroid cancer Year:_____
Pancreatic cancer Year:_____
Lymphoma cancer Year:_____
Leukemia cancer Year:_____

Skin Disease

Don't Know
Eczema
Hives
Athlete's foot
Psoriasis
Acne
Vitiligo
Melasma

Gynecological History

Have you ever been diagnosed with ovarian cysts? Yes No
Have you ever been diagnosed with endometriosis? Yes No
Have you ever been diagnosed with uterine fibroids? Yes No
Have you ever been diagnosed with PCOS? Yes No
Have you ever been diagnosed with fibrocystic breast disease? Yes No
Have you ever had PMS? Mild Moderate Severe Yes No
Have you ever used birth control pills? Yes No
How many years in total have you used birth control pills?
Select... <3 3 - 5 6 - 9 10 - 15 15+
Are you currently taking birth control pills? Yes No
When did you stop? Year:_____
Any Gap? Yes No
Have you stopped having periods? Yes No
Last period :Month/Year: :_____

Obstetric History Male NA

Have you ever experienced postpartum depression? Yes No
How many times have you been pregnant? 0 1 2 3 4 5+
How many times have you given birth ? 0 1 2 3 4 5+
How many of your children are still alive? 0 1 2 3 4 5+
Have you ever had gestational diabetes? Yes No

Surgery & Hospital:

Surgery
Breast lump removal (lumpectomy)
Breast one removed (unilateral mastectomy)
Breasts both removed (bilateral mastectomy)
Breast enlargement (breast augmentation)
Breast reduction
Cataract surgery
Coronary artery blockage (angioplasty)
Open heart surgery (coronary bypass)
Tonsils removed (tonsillectomy)
Thyroid removed
Gall bladder removed (cholecystectomy)
Prostate surgery
Testicular surgery
Uterus removed (hysterectomy) Total Partial
Fibroid of the uterus removed
Cesarean section
D & C (dilation and curettage)
Tubes tied (tubal ligation)
Ovary one removed
Ovaries both removed
Hip replacement
Low back surgery
Colon removed (colostomy)
Hernia repair
Hemorrhoid surgery
Appendix removed (appendectomy)
Other Surgery:_____

Hospitalizations
Pregnancy
Pneumonia
Congestive heart failure
Chest pain
Hardening of the arteries (coronary atherosclerosis)
Heart attack (acute myocardial infarction)
Chronic obstructive lung disease
Stroke (acute cerebrovascular disease)
Irregular heartbeat (cardiac dysrhythmias)
Mood disorders (depression and bipolar disorder)
Dehydration
Urinary infections (severe)
Asthma
Diabetes

Skin infections
Infection of blood stream (sepsis)
Gallbladder disease
Gastrointestinal bleeding
Hip fracture
Appendicitis
Add Hospitalization _____

Social History:

Occupation Unemployed Employed Semi-retired Retired
Occupation _____

Sexual Orientation
Select... Heterosexual (Straight) Homosexual (Gay) Bisexual Non-binary
Are you sexually active? Yes No

Marital Status Single Married Partnered/Significant Other Divorced Widowed

Tobacco use	Yes	No	Quit	Year _____
Alcohol use	Yes	No	In recovery	
Do you believe you have a problem with alcohol?	Yes	No		
Other substances use	Yes	No		
Do you have a history of using recreational drugs?	Yes	No		
Do you currently use recreational or street drugs?	Yes	No		

If Yes what? _____

Children

Do you have any children? Yes No Age of children? _____
Are they living with you? Yes No

Immunizations

Don't Know
Measles
Hepatitis
HPV
Shingles
Whooping cough
Tetanus
Pneumonia
Covid-19

Family History: (Biological parents only)

Parents: Mother: Alive Deceased Father: Alive Deceased
Siblings: How many? _____ Alive x____ Deceased x____
Adopted? Yes No

Family History positive for:

Heart disease/Heart attack Approx. age of first occurrence: _____
Stroke
High blood pressure
High cholesterol
Diabetes
Thyroid disease
Obesity
Osteoporosis
Alzheimer dementia
Mental illness (such as depression, schizophrenia, bipolar disorder)
Alcoholism
Drug abuse
Cancer: Ovarian Uterine Breast Prostate Testicular Stomach Colon
Lung Kidney Bladder Leukemia Lymphoma Skin Brain
Other: _____