**Patient Intake Form**

Please fill out this form and either, email this to **sara@saraweyland.com**, or bring it with you to your 1st appointment.

Name _____________________________________________ Date of 1st appointment ___________________________

Date of birth ___________________________________________ Sex: M / F _____________________________________

Address ________________________________________________________________________________________

________________________________________________________________________________________________

Phone ______________________________________ Email ______________________________________________

Occupation _________________________________ Hobbies ____________________________________________

How did you find out about Sara's clinic (Internet search, referral etc)?

Please list your **primary health concerns**

Please list any **current medications** or **supplements**

Please list any known or suspected **allergies** (including foods, medications, inhalants, herbs, environmental, etc.)

**Past Medical History:** Please list any previous illnesses including significant viral/bacterial infections with approximate dates

**Vaccination History:** Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ MMR (measles, mumps, rubella)
- ☐ Smallpox
- ☐ Haemophilus influenza B (HIB)
- ☐ Tetanus booster
- ☐ Influenza (flu shot)
- ☐ Polio
- ☐ Other ______________________

Have you ever had a bad reaction to any medication, supplement or vaccination? Y / N

If yes, please explain:

# Patient Intake Form

**Symptoms:** Please rate the following that apply to you:

**1**=Occasional; **2**=Frequent; **3**=Always; **P**=Previous issue (no longer experienced)

| **ENERGY** | | **NOSE** | | High cholesterol | | **JOINTS** | |
|---|---|---|---|---|---|---|---|
| Fatigue | | Stuffy or runny | | Irregular beat | | Pain/aches | |
| Apathy | | Loss of smell | | High blood pressure | | Arthritis | |
| Hyperactivity | | Sinus problems | | Chest pain | | Stiffness | |
| Sleeping problems | | Hay fever | | **DIGESTION** | | Weakness | |
| Frequent illness | | Sneezing attacks | | Nausea | | **MUSCLES** | |
| **HEAD** | | Excessive mucus | | Vomiting | | Pain/aches | |
| Faintness | | **MOUTH/THROAT** | | Constipation | | Twitches, spasms | |
| Headaches | | Ulcers/canker sores | | Diarrhoea | | Tension | |
| Migraines | | Throat swelling | | Bloated | | Ltd movement | |
| Dizziness | | Throat closing | | Belching/flatulence | | Weakness | |
| Insomnia | | Cold sores | | Heartburn | | Tiredness | |
| Difficulty falling asleep | | Hoarseness | | Pain | | Coordination prob | |
| **EYES** | | Frequent sighing | | Poor appetite | | **WEIGHT** | |
| Watery | | **SKIN** | | **REPRODUCTIVE/URINARY** | | Excess weight | |
| Itchy | | Acne | | Lack of libido/arousal | | Under weight | |
| Swollen | | Hives, rashes, itching | | Freq/urgent urination | | Craving foods | |
| Sticky | | Dry skin | | Itching anus/genitals | | Compulsive eating | |
| Blurred vision | | Hair loss | | Genital discharge | | Water retention | |
| Swollen lids | | Hair gain | | PMS / PMT | | **MIND** | |
| Dark circles around | | Hot flushes | | Irregular periods | | Poor memory | |
| **EARS** | | Excessive sweating | | Erectile dysfunction | | Confusion | |
| Itchy | | Easy bruising | | **LUNGS** | | Poor concentration | |
| Earaches | | Cold hands/feet | | Congestion | | Mood swings | |
| Drainage | | Eczema/ psoriasis | | Chronic cough | | Anxiety | |
| Ringing | | **HEART** | | Shortness of breath | | Fears | |
| Reddening | | Rapid pounding beat | | Asthma | | Depression | |

Please list any other symptoms not listed above:

**Family History:** Please list any illnesses or diseases that run in your family (siblings, parents, grandparents)

Once you have completed the form, please email this to **sara@saraweyland.com**, or bring it with you to your 1st appointment.

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