Patient Intake Questionnaire

name: date:

Magic Wand

imagine you had a magic wand and could change three things about yourself and your life.

What would they be?

1.

2.

3.

Symptoms

What 3 symptoms are most bothersome?

Strengths/Resources

(examples: What do you have in your life or do for yourself that really helps you? Is there anythings you worked hard for and succeeded? Is there anything you are most proud of?)

Time Line: What major events have happened in your life?

Above Line

- When you when last felt well?
- When each specific symptoms began
- How symptoms have changed
- Anything else you think is important

Below line events

- major events (deaths, births, injuries, divorces, children, other).
- Anything else you think is important

Average Day

What do you do during the day? (example: I wake up at _____ and then I _____, and then I usually _____, and then I usually _____... and then I go to bed at __)

What do you do for fun/pleasure/relaxation?

What brings you a sense of fulfillment?

Who do you connect with?

Do you have a spiritual practice?
If yes, please describe:

Provider Use Only

Habits: Tobacco / alcohol / caffeine / MJ / other

PMHx:

Meds/Supplements:

Sleep	Food and Drinks	Movement	Stress
What time do you go to bed? How long does it take you to get to sleep? How often do you wake up and why? How many hours are you in bed? How many hours are you sleeping? Rate your satisfaction with your sleep *Poor Good Great*	How soon after you wake do you have your first food? How many times do you eat during the day? B: L: D: snacks: How many servings of vegetables a day? Rate your satisfaction with what you eat *Poor Good Great*	How much do you move during the day? Do you have any formal exercise program? Rate your satisfaction with your movement? *Poor Good Great*	Rate your stress? *Low Moderate High* What are your main sources of stress? What do you do to relax? How often do you do it? Does it work?

Making Changes

How much do you want things to change?	How wiling are you to make changes in your daily routine?	How confident are you that you can change your life?	How confident are you that any changes you make will help your situation?
			
comments:	*comments:*	*comments:*	*comments:*

PROVIDERS USE ONLY:

Food: timing/content/portions		Other Notes
Movement: duration/frequency/type		
Sleep: timing/quality		
Relaxation/Stress management		
Fun/Play/Pleasure/Reward		
Mental Health: attitude/belief/identity		EXAM
Environment/Relationships/ Resources		
Supplements		
Manual Medicine/Acupuncture		
Labs/Other		Global Notice