PATIENT INTAKE FORM FOR THE PRACTITIONER

Patient Name:_____

Street:_____ City_____ State_____ Zip_____

Home Phone:_____ Work Phone:_____

Age:_____ Height:_____ Weight:_____ Date of Birth _____

Place of Birth:_____ Social Security Number:_____

Occupation:_____ Partner Status:_____

In Emergency Notify:_____

Referred by:_____

Family Physician:_____

Insurance Carrier:_____ Policy Number:_____

Date_____ Concurrent Health Therapies or Regimens:_____

FAMILY MEDICAL HISTORY

- ☐ Allergies
- ☐ Cancer
- ☐ Seizures
- ☐ Diabetes
- ☐ Stroke, Heart disease
- ☐ Alcoholism
- ☐ Asthma
- ☐ High blood pressure
- ☐ Other_____

PAST MEDICAL HISTORY (WITH DATES)

- ☐ Allergies
- ☐ Cancer
- ☐ Diabetes
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ Heart disease
- ☐ Seizures
- ☐ Rheumatic fever
- ☐ Surgeries
- ☐ Venereal disease
- ☐ Thyroid disease
- ☐ Birth trauma
- ☐ Vaccinations
- ☐ Childhood Illnesses
- ☐ Other significant illnesses
- ☐ Accidents or significant trauma
- ☐ Medications_____

LIFESTYLE AND OCCUPATION

Exercise: _____

Dietary considerations: _____

Habitual consumptions: ☐ Cigarettes ☐ Coffee, tea or cola ☐ Alcoholic beverages ☐ Other

Occupational stress factors:_____

Medications taken within the last two months (vitamins, drugs, herbs, etc.): _____

CURRENT GENERAL HEALTH INDICATORS

- ☐ Poor appetite
- ☐ Disturbed sleep
- ☐ Fatigue
- ☐ Poor coordination
- ☐ Weight gain
- ☐ Cold hands
- ☐ Night Sweats
- ☐ Cold abdomen
- ☐ Tremors
- ☐ Heavy appetite
- ☐ Heavy sleep
- ☐ Localized weakness
- ☐ Strong thirst
- ☐ Weight loss
- ☐ Cold feet
- ☐ Fevers
- ☐ Poor balance
- ☐ Bleeding or bruising easily
- ☐ Changes in appetite
- ☐ Insomnia
- ☐ Sweating easily
- ☐ Cravings
- ☐ Change in appetite
- ☐ Cold back
- ☐ Chills
- ☐ Sensitive to tastes or smells
- ☐ Sudden energy drop (when?)
- ☐ Other unusual or abnormal conditions _____

SKIN AND HAIR

- ☐ Rashes
- ☐ Itching
- ☐ Dandruff
- ☐ Purpura
- ☐ Ulcerations
- ☐ Eczema
- ☐ Hair loss
- ☐ Changes in hair or skin texture
- ☐ Hives
- ☐ Pimples
- ☐ Recent moles
- ☐ Any other hair or skin problems_____

HEAD, EYES, EARS, NOSE, THROAT

- ☐ Dizziness
- ☐ Glasses
- ☐ Eye pain
- ☐ Color blindness
- ☐ Eyestrain
- ☐ Poor hearing
- ☐ Dry throat
- ☐ Sinus problems
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Concussions
- ☐ Spots in front of eyes
- ☐ Poor vision
- ☐ Cataracts
- ☐ Spots in eyes
- ☐ Earaches
- ☐ Dry mouth
- ☐ Recurrent sore throats
- ☐ Sores on lips or tongue
- ☐ Gum problems
- ☐ Migraines
- ☐ Headaches (where? when?)
- ☐ Night blindness
- ☐ Blurry vision
- ☐ Ringing in ears
- ☐ Mucus
- ☐ Copious saliva
- ☐ Nose bleeds
- ☐ Facial pain
- ☐ Jaw clicks

☐ Any other head or neck problems _____

CARDIOVASCULAR

- ☐ Dizziness
- ☐ Irregular heartbeat
- ☐ Cold hands or feet
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Swelling of hands
- ☐ Difficulty in breathing
- ☐ Chest pain
- ☐ Fainting
- ☐ Swelling of feet
- ☐ Phlebitis

☐ Any other heart or blood vessel problems _____

RESPIRATORY

- ☐ Cough
- ☐ Bronchitis
- ☐ Coughing up blood
- ☐ Pain with deep inhalation
- ☐ Asthma _____
- ☐ Pneumonia _____

☐ Difficulty breathing when lying down _____ ☐ Production of phlegm (color?) ____

☐ Any other lung problems _____

GASTROINTESTINAL

- ☐ Nausea
- ☐ Constipation
- ☐ Black stools
- ☐ Bad breath
- ☐ Abdominal pain or cramps
- ☐ Vomiting
- ☐ Gas
- ☐ Blood in stools
- ☐ Rectal pain
- ☐ Chronic laxative use
- ☐ Diarrhea
- ☐ Belching
- ☐ Indigestion
- ☐ Hemorrhoids
- ☐ Sensitive abdomen

☐ Any other GI problems _____

GENITOURINARY

- ☐ Pain on urination
- ☐ Urgency to urinate
- ☐ Decrease in flow
- ☐ Waking at night to urinate
- ☐ Frequent urination
- ☐ Unable to hold urine`
- ☐ Impotence
- ☐ Any particular color to urine
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Sores on genitals

☐ Any other problems with genitourinary function _____

REPRODUCTIVE AND GYNECOLOGIC

Age at menarche _____
Number of live births _____
☐ Menstrual clots
Length of cycle _____
☐ Strong menstrual odor
☐ Vaginal discharge
Birth control method (since _____)

Age at menopause _____
Premature births _____
☐ Painful menses
Duration of menses_____
☐ Other menstrual problems _____
☐ Vaginal odor
☐ Other problems _____

Number of pregnancies _____
Miscarriages/abortions _____
☐ Irregular menses
☐ Premenstrual changes
☐ Breast lumps or swellings

MUSCULOSKELETAL

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pains
- ☐ Muscle pains
- ☐ Muscle weakness
- ☐ Shoulder pains
- ☐ Knee pain
- ☐ Foot/ankle pains
- ☐ Hip pain

Any other joint or bone problems _____

NEUROPSYCHOLOGICAL

- ☐ Seizures _____
- ☐ Areas of numbness _____
- ☐ Concussion _____
- ☐ Bad temper _____
- ☐ Dizziness _____
- ☐ Poor memory _____
- ☐ Depression _____
- ☐ Easily susceptible to stress
- ☐ Loss of balance _____
- ☐ Lack of coordination _____
- ☐ Anxiety _____
- ☐ Treated for emotional problems _____
- ☐ Considered or attempted suicide _____
- ☐ Any other neurological or psychological problems _____

CLASSICAL INDICATIONS AND DIAGNOSTIC INQUIRY—LOOKING, LISTENING, SMELLING:

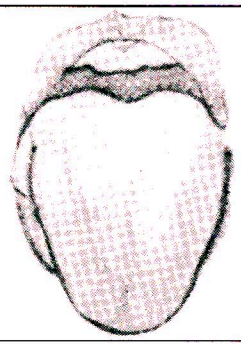
PREFERENCE	MOST LIKED	LEAST LIKED
Season		
Taste		
Climate		
Time of Day		
Mood		

Body type	Yin/Yang Balance
Colors	Firm/Weak
Tones	Hot/Cold
Odors	Surface/Interior

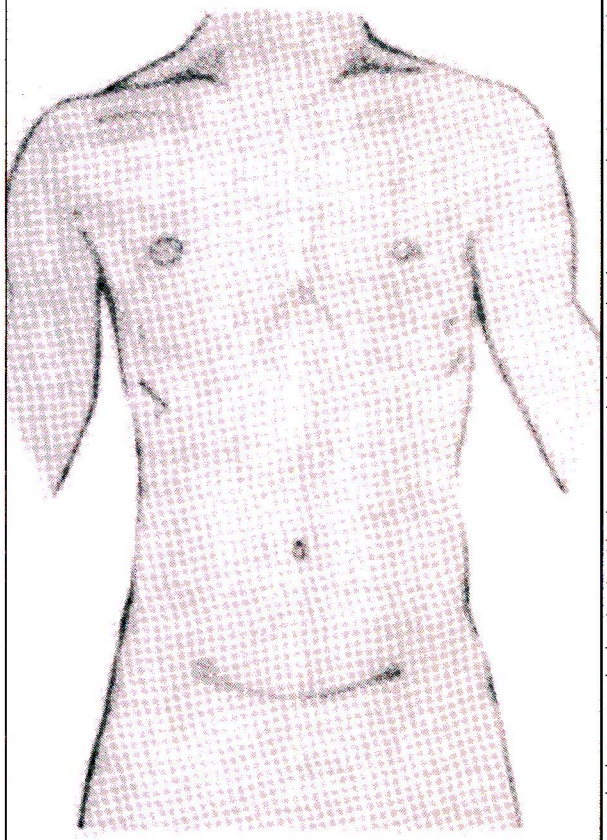
TONGUE

Tongue Qualities

- ☐ Dry
- ☐ Greasy
- ☐ Prickles
- ☐ Curled
- ☐ Ulcerated
- ☐ Moist
- ☐ Peeled
- ☐ Hard
- ☐ Rough
- ☐ Other _____
- ☐ Wet
- ☐ Lolling
- ☐ Loose
- ☐ Swollen

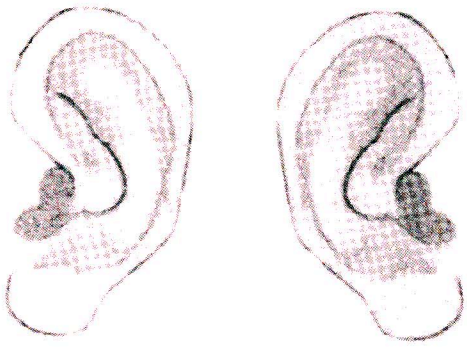


ABDOMINAL PALPATION



Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
−	colder
+	hotter
Physical	
Ø	sores
*	rashes
« »	spasms

EAR



Sensitive Ear Points

PULSE PALPATION

Left Pulse				Right Pulse		
Rear	Middle	Front		Rear	Middle	Front
+	+	+	Superficial	+	+	+
+	+	+	Middle	+	+	+
+	+	+	Deep	+	+	+

Description

Rate _____ Qualities _____

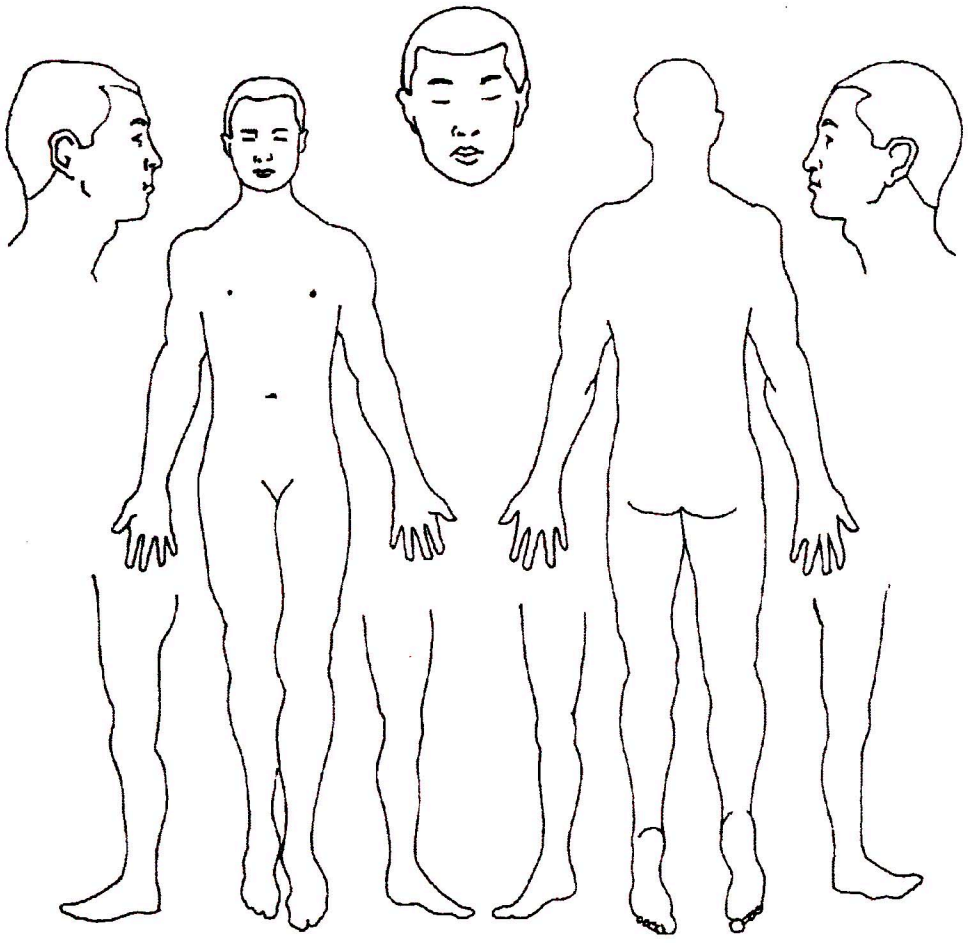
Comments: _____

POINT PALPATION

	HT	SI	PC	TW	LU	LI	SP	ST	KI	BL	LR	GB
	CV-14	CV-4	CV-15(17)	CV-5	LU-1	ST-25	LR-13	CV-12	GB-25	CV-3	LR-14	GB-24
Left												
Right												
	BL-15	BL-27	BL-14	BL-22	BL-13	BL-25	BL-20	BL-21	BL-23	BL-28	BL-18	BL-19
Left												
Right												

AREAS PAINFUL OR DISTRESSED ON PALPATION

Symbol	Reaction
Pain on pressure	
x	little
xx	moderate
xxx	strong
Swelling	
^	slight
^^	moderate
^^^	severe
Tension/weakness	
U	weak
#	tense
Spontaneous pain	
†	slight
††	moderate
†††	severe
Pulsing	
o	slight
oo	moderate
ooo	strong
Temperature	
−	colder
+	hotter
Physical	
Ø	sores
*	rashes
« »	spasms



ASSESSMENT

Objective Symptoms _____

_____

_____

Subjective Symptoms _____

_____

_____

General Diagnosis _____

_____

_____

Treatment Strategy _____

_____

_____

MEDICAL SYMPTOMS QUESTIONNAIRE

Patient Name_____ **Date**_____ **Week**_____

Rate each of the following symptoms based upon your typical health profile for:

_____-Past 30 days _____Past 48 hours

Point scale

0 – Never or almost never have the symptom
1 – Occasionally have it, effect is not severe
2 – Occasionally have it, effect is severe
3 – Frequently have it, effect is not severe
4 – Frequently have it, effect is severe

HEAD	_____	Headaches
	_____	Faintness
	_____	Dizziness
	_____	Insomnia
		Total _____
EYES	_____	Watery or itchy eyes
	_____	Swollen, reddened, or sticky eyelids
	_____	Bags or dark circles under eyes
	_____	Blurred or tunnel Vision
		(does not include near or far-sightedness)
		Total _____
EARS	_____	Itchy ears
	_____	Earaches, ear infections
	_____	Drainage for ear
	_____	Ringing in ears, hearing loss
		Total _____
NOSE	_____	Stuffy nose
	_____	Sinus problems
	_____	Hay fever
	_____	Sneezing attacks
	_____	Excessive mucus formation
		Total _____
MOUTH/ THROAT	_____	Chronic coughing
	_____	Gagging, frequent need to clear throat
	_____	Sore throat, hoarseness, loss of voice
	_____	Swollen or discolored tongue, gums, lips
	_____	Canker Sores
		Total_____
SKIN	_____	Acne
	_____	Hives, rashes, dry skin
	_____	Hair loss
	_____	Flushing, hot flashes
	_____	Excessive sweating
		Total_ _____
HEART	_____	Irregular or skipped heartbeat
	_____	Rapid or pounding heartbeat
	_____	Chest Pain
		Total_____

LUNGS	_____	**Chest congestion**	
	_____	**Asthma, bronchitis**	
	_____	**Shortness of breath**	
	_____	**Difficulty breathing**	
			Total_____
DIGESTIVE TRACT	_____	**Nausea, vomiting**	
	_____	**Diarrhea**	
	_____	**Constipation**	
	_____	**Bloated feeling**	
	_____	**Belching, passing gas**	
	_____	**Heartburn**	
	_____	**Intestinal/stomach pain**	
			Total_____
JOINT/MUSCLE	_____	**Pain or aches in joints**	
	_____	**Arthritis**	
	_____	**Stiffness or limitation of movement**	
	_____	**Pain of aches in muscles**	
	_____	**Feeling of weakness or tiredness**	
			Total_____
WEIGHT	_____	**Binge eating/drinking**	
	_____	**Craving certain foods**	
	_____	**Excessive weight**	
	_____	**Compulsive eating**	
	_____	**Water retention**	
	_____	**Underweight**	
			Total_____
ENERGY/ ACTIVITY	_____	**Fatigue, sluggishness**	
	_____	**Apathy, lethargy**	
	_____	**Hyperactivity**	
	_____	**Restlessness**	
			Total_____
MIND	_____	**Poor memory**	
	_____	**Confusion, poor comprehension**	
	_____	**Poor concentration**	
	_____	**Poor physical coordination**	
	_____	**Difficulty in making decisions**	
	_____	**Stuttering or stammering**	
	_____	**Slurred speech**	
	_____	**Learning disabilities**	
			Total_____
EMOTIONS	_____	**Mood swings**	
	_____	**Anxiety, fear, nervousness**	
	_____	**Depression**	
			Total_____
OTHER	_____	**Frequent Illness**	
	_____	**Frequent or urgent urination**	
	_____	**Genital itch or discharge**	
			Total_____
GRAND TOTAL			**TOTAL** _____

Toxicity Questionnaire

The Toxicity Questionnaire is designed to aid the practitioner in assessing a patient's or client's potential need for a Clinical Purification™ program.

Section I: Symptoms

Rate each of the following based upon your health profile for the past 90 days.

Circle the corresponding number.	
0	Rarely or Never Experience the Symptom
1	Occasionally Experience the Symptom, Effect is Not Severe
2	Occasionally Experience the Symptom, Effect is Severe
3	Frequently Experience the Symptom, Effect is Not Severe
4	Frequently Experience the Symptom, Effect is Severe

1. DIGESTIVE

a. Nausea and/or vomiting	0	1	2	3	4
b. Diarrhea	0	1	2	3	4
c. Constipation	0	1	2	3	4
d. Bloated feeling	0	1	2	3	4
e. Belching and/or passing gas	0	1	2	3	4
f. Heartburn	0	1	2	3	4

Total: _____

2. EARS

a. Itchy ears	0	1	2	3	4
b. Earaches or ear infections	0	1	2	3	4
c. Drainage from ear	0	1	2	3	4
d. Ringing in ears or hearing loss	0	1	2	3	4

Total: _____

3. EMOTIONS

a. Mood swings	0	1	2	3	4
b. Anxiety, fear, or nervousness	0	1	2	3	4
c. Anger, irritability	0	1	2	3	4
d. Depression	0	1	2	3	4
e. Sense of despair	0	1	2	3	4
f. Uncaring or disinterest	0	1	2	3	4

Total: _____

4. ENERGY / ACTIVITY

a. Fatigue or sluggishness	0	1	2	3	4
b. Hyperactivity	0	1	2	3	4
c. Restlessness	0	1	2	3	4
d. Insomnia	0	1	2	3	4
e. Startled awake at night	0	1	2	3	4

Total: _____

5. EYES

a. Watery or itchy eyes	0	1	2	3	4
b. Swollen, reddened, or sticky eyelids	0	1	2	3	4
c. Dark circles under eyes	0	1	2	3	4
d. Blurred or tunnel vision	0	1	2	3	4

Total: _____

6. HEAD

a. Headaches	0	1	2	3	4
b. Faintness	0	1	2	3	4
c. Dizziness	0	1	2	3	4
d. Pressure	0	1	2	3	4

Total: _____

7. LUNGS

a. Chest congestion	0	1	2	3	4
b. Asthma or bronchitis	0	1	2	3	4
c. Shortness of breath	0	1	2	3	4
d. Difficulty breathing	0	1	2	3	4

Total: _____

8. MIND

a. Poor memory	0	1	2	3	4
b. Confusion	0	1	2	3	4
c. Poor concentration	0	1	2	3	4
d. Poor coordination	0	1	2	3	4
e. Difficulty making decisions	0	1	2	3	4
f. Stuttering, stammering	0	1	2	3	4
g. Slurred speech	0	1	2	3	4
h. Learning disabilities	0	1	2	3	4

Total: _____

9. MOUTH / THROAT

a. Chronic coughing	0	1	2	3	4
b. Gagging or frequent need to clear throat	0	1	2	3	4
c. Swollen or discolored tongue, gums, lips	0	1	2	3	4
d. Canker sores	0	1	2	3	4

Total: _____

10. NOSE

a. Stuffy nose	0	1	2	3	4
b. Sinus problems	0	1	2	3	4
c. Hay fever	0	1	2	3	4
d. Sneezing attacks	0	1	2	3	4
e. Excessive mucous	0	1	2	3	4

Total: _____

11. SKIN

a. Acne	0	1	2	3	4
b. Hives, rashes, or dry skin	0	1	2	3	4
c. Hair loss	0	1	2	3	4
d. Flushing	0	1	2	3	4
e. Excessive sweating	0	1	2	3	4

Total: _____

12. HEART

a. Skipped heartbeats	0	1	2	3	4
b. Rapid heartbeats	0	1	2	3	4
c. Chest pain	0	1	2	3	4

Total: _____

13. JOINTS / MUSCLES

a. Pain or aches in joints	0	1	2	3	4
b. Rheumatoid arthritis	0	1	2	3	4
c. Osteoarthritis	0	1	2	3	4
d. Stiffness or limited movement	0	1	2	3	4
e. Pain or aches in muscles	0	1	2	3	4
f. Recurrent back aches	0	1	2	3	4
g. Feeling of weakness or tiredness	0	1	2	3	4

Total: _____

14. WEIGHT

a. Binge eating or drinking	0	1	2	3	4
b. Craving certain foods	0	1	2	3	4
c. Excessive weight	0	1	2	3	4
d. Compulsive eating	0	1	2	3	4
e. Water retention	0	1	2	3	4
f. Underweight	0	1	2	3	4

Total: _____

15. OTHER

a. Frequent illness	0	1	2	3	4
b. Frequent or urgent urination	0	1	2	3	4
c. Leaky bladder	0	1	2	3	4
d. Genital itch, discharge	0	1	2	3	4

Total: _____

Section I Total: _____

Section II: Risk of Exposure

Rate each of the following situations based upon your environmental profile for the past 120 days.

16.	Circle the corresponding number for questions 16a - 16f below.									
0	Never	1	Rarely	2	Monthly	3	Weekly	4	Daily	

a. How often are strong chemicals used in your home? (disinfectants, bleaches, oven and drain cleaners, furniture polish, floor wax, window cleaners, etc.)	0	1	2	3	4
b. How often are pesticides used in your home?	0	1	2	3	4
c. How often do you have your home treated for insects?	0	1	2	3	4
d. How often are you exposed to dust, overstuffed furniture, tobacco smoke, mothballs, incense, or varnish in your home or office?	0	1	2	3	4
e. How often are you exposed to nail polish, perfume, hair spray, or other cosmetics?	0	1	2	3	4
f. How often are you exposed to diesel fumes, exhaust fumes, or gasoline fumes?	0	1	2	3	4

Total: _____

17.	Circle the corresponding number for questions 17a - 17b below.							
0	No	1	Mild Change	2	Moderate Change	3	Drastic Change	

a. Have you noticed any negative change in your health since you moved into your home or apartment?	0	1	2	3
b. Have you noticed any negative change in your health since you started your new job?	0	1	2	3

Total: _____

18.	Answer yes or no and circle the corresponding number for questions 18a - 18d below.		
		No	Yes
a. Do you have a water purification system in your home?		2	0
b. Do you have any indoor pets?		0	2
c. Do you have an air purification system in your home?		2	0
d. Are you a dentist, painter, farm worker, or construction worker?		0	2

Total: _____

Section II Total: _____

GRAND TOTAL (Section I + Section II) _____

Add up the numbers to arrive at a total for each section, and then add the totals for each section to arrive at the grand total. If any individual section total is 6 or more, or the grand total is 40 or more, you may benefit from a Clinical Purification™ program.

Adapted with permission from the author of *Clinical Purification™: A Complete Treatment and Reference Manual*, Dr. Gina L. Nick.