P Sharise Clostio, PLLC
429 1st St W
Kalispell, Montana, US - 59901

Initial Intake Form

Chief Complaint or Reason For Visit:

Full Name: *

Preferred method of contact : * ☐ Phone Call ☐ Email

How were you referred to us? * ☐ Patient Referral ☐ Yelp ☐ Health Profs ☐ HCG Doctor's Directory ☐ Bioidentical Hormones Directory ☐ Friend or Family Member ☐ Google

If you were referred by a current patient please let us know by who so we can contact them to say thanks

Phone number *

Home Address with street, house number, city and zip code *

Billing Zip Code *

Marital status * ☐ Single ☐ Married ☐ In a relationship

Height : *

Weight : *

Goal Weight *

Occupation : *

How many children do you have? *

Emergency Contact Name : *

Phone : *

Relationship : *

Medical History

Primary health care provider : *

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Other healthcare providers: *

List your chief health concerns in the order of importance to you. Also include when they started. *

List any medical diagnosis you have received (i.e. diabetes, heart disease, depression, etc.) *

List any prescription medications you take including dosages and reason for taking them *

List any over counter medications or supplements you take and the reason for taking them *

List any surgeries, hospitalizations, accidents, serious illnesses and/or injuries *

Any known allergies to medications? * ☐ Yes ☐ No

If yes, specify them

Any known food or environmental allergies? * ☐ Yes ☐ No

If yes, specify them

Are any of your allergies life threatening? * ☐ Yes ☐ No

If yes, specify them

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Has anyone in your family been affected by any of the following. Please check all that apply and (Mother, Father, Grandparents, Siblings, Children) *

- ☐ AIDS/HIV
- ☐ Alcoholism
- ☐ Allergies
- ☐ Anemia
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
- ☐ Depression
- ☐ Diabetes
- ☐ Drug Problems
- ☐ Eczema
- ☐ Gout
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Hypoglycemia
- ☐ Kidney disorder
- ☐ Mental Illness
- ☐ Migraines
- ☐ Obesity
- ☐ Psoriasis
- ☐ Seizures
- ☐ Stroke
- ☐ Suicide
- ☐ TB
- ☐ Thyroid problems
- ☐ Ulcer
- ☐ Other

Family History

Symptoms

For the following symptoms list how often you experience them - often, sometimes, never or in the past.

General :

Sleep disturbance *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Fatigue *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Exposure to toxic chemicals *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Iron deficiency anemia *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Head

Headaches or migraines *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Difficulty concentrating *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Memory problems *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Head injury *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

Ears, Eyes, Nose, Throat

Frequent colds *
- ☐ Often
- ☐ Sometimes
- ☐ Never
- ☐ In the past

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Sinus congestion or infections *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Mouth sores *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Dental/gum infections *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Cracked lips *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Recent changes in vision *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Dry eyes *	☐ Often ☐ In the past	☐ Sometimes	☐ Never

Skin

Acne *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Eczema *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Dry skin *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Easy bruising/bleeding *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Skin rashes *	☐ Often ☐ In the past	☐ Sometimes	☐ Never

Digestion

Stomach pain and or/ cramps *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Acid reflux / heartburn *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Constipation *	☐ Often ☐ In the past	☐ Sometimes	☐ Never
Loose stools or diarrhea *	☐ Often ☐ In the past	☐ Sometimes	☐ Never

Bowel Movement Daily * ☐ Yes ☐ No

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Abdominal bloating or gas *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Nausea or vomiting *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Mental / Emotional

ADD / ADHD *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Food cravings *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Mood swings or mood disorders *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Irritability *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Depression *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Anxiety/nervousness *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Cardiovascular

Heart disease *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
High blood pressure *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Heart palpitations *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Cold hands and feet *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Varicose veins *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Swelling of hands and feet *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Respiratory

Chronic Cough *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

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Asthma *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Shortness of breath *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Sleep apnea *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Neurological

Seizures *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Numbness and tingling *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Loss of balance *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Musculoskeletal

Joint pain or stiffness *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Neck/back pain *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Muscle weakness *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Muscle spasms or cramps *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Osteopenia/osteoporosis *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Urinary

Burning or pain during urination *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Frequent urination at night *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Inability to hold urine *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Bladder infections *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

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Endocrine

Low libido *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Easy weight gain *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Hair loss *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Heat or cold intolerance *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Thyroid problems *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Blood sugar problems *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

For Women :

Contraceptive Use *	☐ Yes	☐ No	
If yes, what type			
Absent periods *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Irregular cycle *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
PMS *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Heavy bleeding or spotting between cycles *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Cervical Dysplasia/ HPV *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Yeast Infections *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Endometriosis *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
PCOS *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

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Uterine fibroids *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Difficult menopause - hot flashes, night sweat *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Vaginal dryness *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Infertility *	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
History of Miscarriage *	☐ Yes	☐ No	
Recent changes in breasts *	☐ Yes	☐ No	
Nipple discharge *	☐ Yes	☐ No	
Date of last PAP exam *	_____		
History or abnormal PAP exam *	☐ Yes	☐ No	

For Men :

Prostate problems	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Erectile dysfunction	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Use of Viagra	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Infertility	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		
Difficult urination	☐ Often	☐ Sometimes	☐ Never
	☐ In the past		

Lifestyle

Do you exercise? *	☐ Yes	☐ No	
If yes, indicate number of times you exercise during the week as well as the type of exercise			
How many alcoholic drinks per week? *	☐ 0-2	☐ 2-4	☐ 4+

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Do you smoke? * ☐ Yes ☐ No ☐ In the past

Do you use recreational drugs? * ☐ Yes ☐ No

Rate your current stress level(5 being the highest) * ☐ 1 ☐ 2 ☐ 3 ☐ 4 ☐ 5

What are the primary sources of your stress? *

Do you eat fast food * ☐ Yes ☐ No

If yes, number of times per week _____

Do you eat out (not fast food) * ☐ Yes ☐ No

If yes, number of times per week (not including fast food) _____

Number of times you eat per day * _____

Amount of soda (including diet) you drink in a typical day * _____

How many cups of coffee do you drink per day? * ☐ 0 ☐ 1-2 ☐ 2-4 ☐ 4+

How many glasses of water do you drink in a day? * ☐ 1-3 ☐ 3-5 ☐ 6-8 ☐ 8+

Health Goals

What are your main health goals? *

How motivated are you to reach your goals? * _____

How willing are you to change your eating habits to reach your goal? * ☐ Strongly willing ☐ Moderately willing ☐ Not willing ☐ Cannot say

What is your timeframe for reaching your goal? * _____