Patient Intake Form

Return completed form Kathleen MacIsaac, MD, PLLC Integrative & Functional Medicine at least one week prior to your appointment.

If you need to cancel or change your appointment, please call 540-527-7323 as soon as possible.

Personal Information

Date____________

Full Name____

Age______________________ Date of Birth____

Parents name if minor ____

Address____

City ___________________________State________________________ Zip______________________

Phone: Home ___________________________________ Cell__________________________________

E-mail ____

Marital Status ________________ Children (ages)____

In case of emergency, call:

Name _______________________________________ Phone _________________________________

How did you hear about us? ____

Primary Care Physician? _______________________________ Date of last visit: _______________

When and where did you last receive health care? _______________________________________

For what reason? ____

Concerns	**Onset**	**Frequency**	**Severity**
(please rank by priority) *Example: Headache*	*Example: June 2010*	*Example: 4 times/week*	*Example: mild/mod/severe*

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Current Symptoms:

Please Circle All that Apply

Abdominal Pain
Frequent Urination
Nosebleeds
Back Pain
Hair Loss
Numbness/ Tingling
Blood in Urine
Headaches
Pain/ Bleeding during Sex
Bloody/ tarry stool
Hemorrhoids
Painful Urination
Bruise Easily
Hernia
Phobias
Change in bowel habits
Hives
Rashes
Chest Pain

Hoarseness
Ringing in Ears
Cold numb feet
Indigestion/ Heartburn
Sexual Dysfunction
Constipation
Insomnia
Shortness of Breath
Convulsions/ Seizures
Joint Pain
Sinus Trouble
Cough
Leg Pain
Sore Throat
Diarrhea
Loss of Appetite
Swollen Ankles
Difficulty Swallowing
Lumps/ Masses

Tooth/ Gum Trouble
Dizziness/ Fainting
Memory Loss
Tremors
Ear Infection
Moodiness
Urethral Discharge
Failing Vision
Muscle Weakness
Varicose Veins
Fatigue
Nausea/ Vomiting
Weight Loss
Fever
Nervousness
Foot Pain
Night Sweats
Lack of energy

Do you use any of the following:

	Yes	Never	Quit	Amount Per Day
Recreational Drugs				
Alcohol				
Tobacco				
Caffeine				

Do you know if you have ever been exposed to harmful environmental substances?

____

____

Patient Medical History

Please Circle All That Apply

AIDS
Eczema
Multiple Sclerosis
Anemia
Emphysema
Mumps
Anxiety
Epilepsy
Muscle Disorder
Arrhythmia
Eye/ Ear Disorder
Neuropathy
Arthritis
Genetic Defects
Osteoporosis
Asthma
Gout
Parkinson's Disease
Birth Defect:
____
Hay fever/ Allergies
Phlebitis
Blood Disorder/ Clot
Heart Attack

Pneumonia
Bone/ Joint Disorder
Heart Disease
Polio
Bronchitis
Heart Murmur
Prostate
Disease
Cancer: Type
____
Hepatitis: Type _______
Psoriasis
Chicken Pox
Herpes
Rubella
Cirrhosis/ Liver
High Blood Pressure
Seizures
Colitis
Jaundice
Skin Disease
Congestive Heart Failure
Kidney Failure
Sleep

Apnea
COPD
Kidney Stones
Stroke
Crohn's Disease
Lactose Intolerant
Tetanus
Deep Vein Thrombosis
Low Blood Pressure
High Cholesterol
Thyroid Disease
Depression
Lung Disease
Tuberculosis
Diabetes
Measles
Ulcers
Diphtheria
Mental Illness
Venereal Disease
Diverticulosis
Migraines
Other: ________________

Allergies:

____

____

Current medications:

____

____

Supplements, vitamins or herbs:

____

____

Family History

Mother ____

Father ____

Brothers/Sisters ____

Grandparents ____

Female Reproductive

Age of First Menses __________________
# of Days of Menses _________________
Date of Last Pap Smear _______________
Result of Last Pap Smear ______________
Birth Control Type ___________________

# of Pregnancies __________________
# of Miscarriages __________________
# of Abortions _____________________
# of Live Births ____________________
Date of Last Menses ________________

Menopause: Pre _____________ Post ___________ Problems _________________________

Male Reproductive

Please Circle All That Apply

Erectile Dysfunction
Prostate problems
Trouble Passing Urine
Urinary Frequency
Testicular Pain/Swelling

How many times to you wake up to urinate: ______________________________________

Nutrition Diary

Please list all foods and drinks you have consumed in the previous 24 hours. Include meals, snacks, beverages, and condiments.

____
____
____
____
____

Is this a typical day? If not why?

____
____

Do you have any food allergies or intolerances?

____
____

Are there any types or groups of food you crave or eat a lot?

____
____

What do you drink on a typical day?

____
____

Acknowledgement of Receipt of Dr Kathleen MacIsaac, MD, PLLC Integrative & Functional Medicine Notice of Practices

Insurance:

Dr. MacIsaac's office does not file claims with insurance companies. We can give you a superbill when requested for your visit, but it is your responsibility to file that with your insurance company. Should the insurance company send us information regarding your claim or visit, we will mail or email that information to you in a timely manner, but we will not correspond with your insurance company.

_________ Initial

Integrative & Functional Medicine vs. Primary Care:

The services and recommendations we render are intended to supplement the already existing relationship you have with your primary care physician. Our recommendations are made with the goal of optimal health in mind and are not intended to diagnose or treat any serious or chronic medical conditions.

_________ Initial

Fee for Service:

All appointments and supplements are available on a fee for service basis. Full Payment for office time, testing and supplements is required at the time of the appointment. We accept all major credit cards, cash and check.

_________ Initial

Cancellations & Late Arrivals:

To continue to provide prompt attention to each of our clients we ask that you arrive on time for your appointment. Cancellations must be within 48 hours for a new patient appointment and 24 hours for a regularly scheduled appointment. Dr MacIsaac reserves the right to charge up to 100% for those patients that do not cancel within the designated amount of time.

_________ Initial