Dee S. Weir • 410.707.6198

9170 Route 108, Suite 202 • Columbia, MD 21045
located at the Howard County Holistic Center

Intake Form

I. General Information

Date _____

Name_____ Sex M F

Address_____ City _____ State_____ Zip_____

Phone ( ) _____ Work ( ) _____ Cell ( ) _____

Date of Birth_____ Occupation_____

Marital Status: Single Married Widow(er) Divorced

Emergency contact information: Name_____ Phone ( ) _____

Are you currently under a physician's care?_____ For what reason? _____

_____

Family Physician_____

Address_____ Phone ( ) _____

List all prescription medication you are currently taking:_____

_____

List all non-prescription medication you are currently taking: _____

_____

Are you under the care of any other type of health care worker? _____

If so, list name and phone number _____ How long have you been treated? _____

II. Treatment Focus

Who referred you to this office? _____

What is your chief concern? _____

_____

What are your goals for your health? _____

_____

List current symptoms or problems._____

_____

III. Review Of Symptoms

Place an **X** next to any problems you currently have and a **P** next to problems you have had in the past.

____ muscle cramps	____ difficult digestion	____ osteoporosis	____ anemia
____ insomnia	____ skin conditions	____ high/low blood pressure	____ diabetes
____ fatigue	____ bone injuries	____ anxiety	____ frequent colds and/or flu
____ sinus pressure	____ headaches	____vericose veins	____ neck pain
____ cold hands/feet	____ heart disease	____ asthma	
____ sciatic	____ diarrhea	____ disc problems	
____ heart palpitations	____ constipation	____ vision problems	

IV. Medical History

Do you have allergies? If so, to what? _____

Recent Surgery? Describe: _____

_____

Menstrual Problems? Clotting, Heavy/Light Flow, Irregularity, PMS, Spotting, Cramps: (Circle any that apply).

Is there any possibility of being pregnant? If so, in what week? _____

Muscle Tension? Indicate where: