ORPHEUS HOLISTIC HEALTH CLINIC
Dr. YULIYA KLOPOUH, M.H, Pharm.D.
Patient Intake Form

<table>
<tr><td>Thank you for considering Orpheus Health Clinic. Please help us provide you with a complete evaluation by taking the time to fill out this questionnaire carefully. All your information will be confidential. If you have questions, please ask.

Sex__F__M Date____/____/____</td></tr>
<tr><td>Date of birth : ____/____/__________/ Age Occupation</td></tr>
<tr><td>Height______'_____" Weight now_____________ Weight one year ago_________________</td></tr>
<tr><td>Main phone # ( ) Other phone #( )</td></tr>
<tr><td>Emergency contact name phone # Relationship</td></tr>
<tr><td>Marital status # of children</td></tr>
<tr><td>E-mail address</td></tr>
<tr><td>Address:Street City State Zip</td></tr>
<tr><td>Family physician</td></tr>
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Main problem(s): ____

What diagnosis, if any, have you received for this problem? _______________________________________

When did this problem begin? _____________ What are the causes of this problem?________________________

To what extent does this problem interfere with your daily activities (work, sleep, sex, etc.)?_________________

What kind of treatment have you tried? ____

What makes this problem worse? ____

What makes this problem better? ____

Is there anybody in your family with the same/similar problems? __________ Remarks and additional information:

Medical History (Please include the month/year when the event occurred or when the diagnosis was established)

Surgeries: ____________________________________**__Hospitalization**: ___________________________

Significant trauma: (auto accidents, sports injuries, etc) ____
Allergies: (drugs, chemicals, foods, environmental):____

Diagnosis	Self	Family	Diagnosis	Self	Family	Diagnosis	Self	Family
Cancer (what type)			Diabetes			Thyroid disease		
Breathing problems			Tuberculosis			Anemia		
High blood pressure			Venereal disease			Heart disease		
Depression or anxiety			Emotional disorders			Arthritis		
Seizures			Alcoholism			Other		

Medicines taken within the last two months (including vitamins, OTC drugs, herbs, etc., and their dosages):

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Occupation: ______________________________ Do you usually work __indoors __ outdoors?

Occupational stress (chemical, physical, psychological, etc):____

Habits Do you smoke ? __Yes __No What? __________ How many per day? __________ Since when?________

Please describe any use of drugs for non-medical purposes:____

Do you exercise regularly __Yes __No Please describe your exercise program: ____________________________

How many hours do you sleep in general? ___________ When time do you usually go to bed? ________________

Diet How much coffee do you drink? _______cups/day Colas ________number/day Tea _______ cups/day
What kind of alcoholic beverages do you usually drink, if any? _______ Average number of drinks/week? _______
How much water do you drink per day? _______
Are you a vegetarian? __Yes __No __Yes, but not so strict Do you eat a lot of spicy food? __Yes __No
Remarks and additional information (e.g. diet) ____
Please describe your average daily diet (Please be as specific as possible):

Morning ____

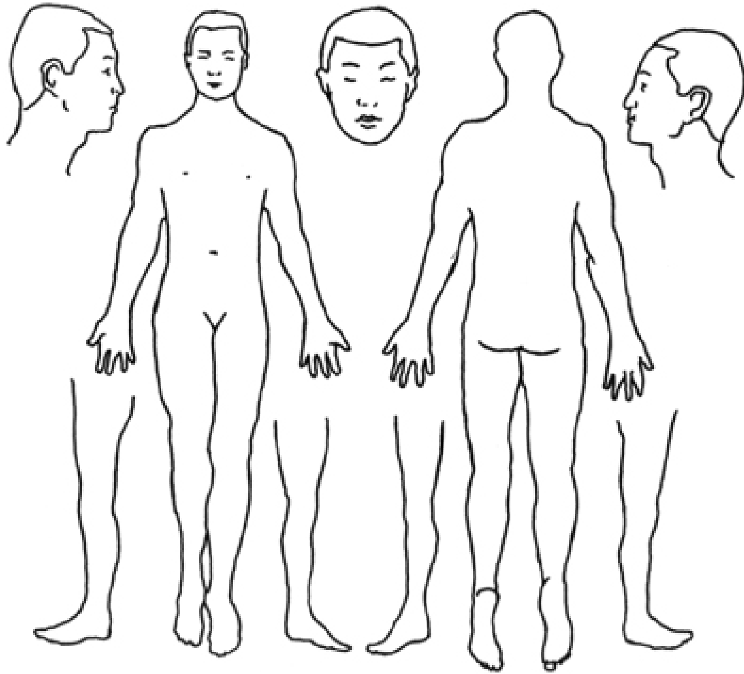
Afternoon ____

Evening ____

Snacks ____

Indicate painful or distressed areas:

____



Please check if you have or have had (in the last three months) any of the following diseases or conditions.

General __Poor appetite __Poor sleep __Fatigue __Fevers __Chills__ Night sweats __Sweat easily __Tremors __Cravings __Change in appetite__ Poor balance __Bleed or bruise easily __Localized weakness __Weight loss __Weight gain__Peculiar tastes __Desire hot food __Desire cold food __Strong thirst (cold or hot drinks) __Sudden energy drop (What time of day) _______ Favorite time of year ________ Worst time of year _________

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Skin & hair __Rashes __Ulcerations __Hives __Itching __Eczema__ Pimples __Acne __Dandruff __Dry skin __Recent moles __Loss of hair__ Purpura __Change in hair or skin texture __Other?

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Musculoskeletal __Joint disorders __Muscle weakness __Pain/soreness in the muscles __Tremors__ Cold hands/feet __Difficulty walking __Swelling of hands/feet __Spinal curvature __Back pain __Hernia__ Numbness __Tingling __Paralysis__ Neck tightnes_ _Neck pain __Shoulder pain__ Hand/wrist pain __Hip pain __Knee pain __Joint Sprain __Other?

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Head, eyes, ears, nose, and throat __Dizziness __Concussions __Migraines __Glasses/lens__ Eye strain __Eye pain __Color blindness __Night blindness __Poor vision __Cataracts__ Blurry vision __Earaches __Ringing in ears __Poor hearing__ Spots in front of eyes__ Sinus problems __Nose bleeding __Sore throat __Grinding teeth __Teeth problems __Facial pain__ Jaw clicks __Sores on lips/tongue __ Difficulty swallowing __Other?

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Cardiovascular __High blood pressure __Low blood pressure __Chest pain __Palpitation __Fainting__ Phlebitis __Irregular heartbeat __Rapid heartbeat __Varicose veins _-Other?

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Respiratory __Cough __Coughing blood __Wheezing __Difficulty breathing__ Bronchitis __Pneumonia __Chest pain __Production of phlegm – What color?

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Gastrointestinal__ Nausea __Vomiting __Diarrhea __Constipation __Gas Belching __Black stools __Blood in

stools __Indigestion __Bad breath __Rectal pain__ Hemorrhoids __Abdominal pain/cramps __Gallbladder problems __Parasites __Chronic laxative use Bowel movements: Frequency _______ Color ______ Odor ______ Texture/ Form _______________

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Neuro-psychological __Loss of balance __Lack of coordination __Concussion__ Depression __Anxiety __Stress __Bad temper __Bi-polar

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Genito-urinary __Painful urination __Frequent urination __Blood in urine __Urgency to urinate__ Kidney stones __Unable to hold urine __Dribbling __Pause of flow __Frequent urinary tract infection__ Genital pain __Genital itching __Genital rashes __STD __Other?

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Female__Frequent vaginal infections __Pelvic infection __Endometriosis __Vaginal/genital discharge__ Fibroids __Ovarian cysts __Irregular periods __Clots __Pain/cramps prior/during periods__ Breast tenderness __Breast Lumps __Fertility Problems__Hot flashes __Moodiness related to periods

______ Number of pregnancies ______ Number of births ______ Miscarriages ______ Abortions

______ Premature births ______ C-section ______ Difficult delivery

First date of last period ___________Age of first period ______ Duration of periods ______days, cycle ____ days

Do you practice birth control ? Yes No. If yes, what type and for how long? ________________________________

If you're on birth control pills, what are you taking and for how long? _____________________________________

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Male__Prostate problems __Discharge __Erectile dysfunction __Ejaculation problems__ Frequent seminal emission __Fertility problems __Painful/swollen testicles __Other

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I have completed this form correctly to the best of my knowledge.

Signature: __Adult Patient _-Parent or Guardian __Spouse

Are there any other health issues you want to discuss with us?

Signature Date