Elissa Viarengo
Alternative Health Care Practitioner
970-481-7536
elissaviarengo@yahoo.com

New Patient Intake Form

Name:_____

If a minor, Name of Parents / Guardian: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Home Telephone (with area code): _____

Work Telephone (with area code): _____

Cell Phone (with area code): _____

Email address (for newsletters / discounts): _____

Date of Birth (month/date/year): _____ Age: _____ Sex: _____

Occupation: _____

Who referred you to Elissa Viarengo? _____

What is the main reason you are seeking care?

_____
_____
_____
_____

updated 12/1/14

Surgeries / Major Illnesses: _____
_____
_____

Other Practitioners You See:
M.D._____Chiropractor: _____
Acupuncturist: _____ Naturopath: _____
Massage Therapist:_____ Physical Therapist: _____
Other: _____

Medications You Are Currently Taking

Name	Reason for Taking	Frequency of use

Supplements/ Vitamins / Homeopathics / Herbs You Are Currently Taking

Name	Reason for taking	Frequency of use

Health Habits

Do you use…	How Often?
Caffeine:	
Alcohol:	
Tobacco:	

Hours of Sleep _____ Do you feel rested upon waking? _____
Do you exercise? _____
What kind and Frequency? _____
_____

Please indicate the symptoms you are **CURRENTLY** having or have **REGULARLY throughout the year**

___ Absent Minded
___ Abdominal Bloating
___ Acne
___ Acid Reflux
___ Addiction to Alcohol
___ Addiction to Drugs
___ Addiction to Tobacco
___ Appetite - Excessive / Low
___ Arthritis
___ Asthma
___ Bad Breath
___ Burping
___ Body Odor
___ Blood Pressure – High / Low
___ Breast Pain / Swelling / Lumps
___ Canker Sores / Cold Sores
___ Colds – Frequently get
___ Colitis
___ Constipation
___ Cough
___ Crave Salt / Sour / Sweet
___ Diarrhea
___ Digestive Troubles
___ Dizziness
___ Dreams - Disturbing
___ Dry Skin / Dry Eyes
___ Ears Ache / Infection / Congested
___ Ear Ringing
___ Eating Disorder
___ Edema (swelling)
___ Excessive Thirst
___ Eyes – Watery
___ Eyes – Red / Puffy / Itchy
___ Eye – Vision Problems
___ Fatigue
___ Fungus
___ Gas
___ Gums Swollen / Red
___ Hay Fever
___ Headaches
___ High Alt. Problems
___ Hot Flashes
___ Hoarseness
___ Humidity Discomfort
___ Hyperactivity
___ Indigestion
___ Insomnia
___ Irritable Bowel
___ Joint Pain / Swelling
___ Infections
___ Loss of Taste/ Smell
___ Lump in Throat
___ Menses - Difficulty
___ Mental Confusion
___ Metallic Taste
___ Moody
___ Motion Sickness
___ Muscle Cramps
___ Muscle Spasms
___ Nasal Polyps
___ Nasal Congestion
___ Nasal Drip
___ Nausea
___ Nervous Stomach
___ Night Sweats
___ Numbness
___ Psoriasis
___ Restless Leg

___ Seizures
___ Shortness of Breath
___ Sinusitis
___ Skin Rash
___ Skin Itch
___ Skin Burning
___ Sleeping Problems
___ Sneezing
___ Sore Throat
___ Stomach Discomfort
___ Swollen Glands
___ Teeth Pain
___ Tongue Swelling
___ Throat Constriction
___ Tightness in Chest
___ Tires Easily
___ Urinary Tract Disorders
___ Urination Painful / Burning
___ Vomiting
___ Weight Loss / Gain
___ Yeast Infections

Any other symptoms: _____
_____
_____

Please List Any Known Allergies: _____
_____
_____

Please List Dietary Restrictions (foods you avoid): _____
_____
_____

Is there anything else you would like Elissa to know about your health?
_____
_____
_____