Standard Intake Questionnaire

Demographic information	
Name:	**DOB:**
Contact number:	**Email:**
Address:	
Emergency contact	
Name:	**Number:**
Reason for visit	
Brief description of reason including symptoms:	
Timeline of symptoms - when did they occur, duration:	
Impact on daily life:	
Identification of factors that improve or worsen symptoms:	
Recognition of triggers that may influence the condition:	

Medical history
Past illnesses and surgeries:
Current medications:
Any known allergies:
Immunization history:
Mental health history (current mental health concerns, previous diagnoses, past treatments):
Family history:

Lifestyle habits	
Diet (including dietary requirements):	
Exercise and other activity levels:	
Sleep patterns:	
Use of tobacco, alcohol, or other substances:	
Additional notes	
Healthcare provider:	**Signature:**
Date:	**Clinic/facility:**