Grandview Primary Care
& Performance Medicine Institute
842 Grandview Ave.
Columbus, Ohio 43215
(P) 614-437-9002; (F) 614-336-8557
Dr. Shawn C Bailey

Health Intake Form

Please take time to fill out this questionnaire carefully. The information you provide will assist me, and my multi-disciplinary team, in formulation a complete health profile for you. This information is crucial for constructing a therapeutic treatment plan for you. All answers and information given on this form are confidential.

Today's Date: ____/____/_____

Name: _____ Date of Birth: ____/____/_____

Address: _____ City/ State/ Zip: _____

Email Address: _____ Best Phone #: _____

Gender: _____ Marital Status: _____ Occupation: _____

Emergency Contact/ Relationship/ Phone #: _____

Are you currently (or within the past year been) under the care of a Primary Care Physician: _____

If so, who is your Primary Care Physician: _____

Describe your **main concerns** for initiating this point of care: (Symptoms, onset, diagnoses, duration, etc.)

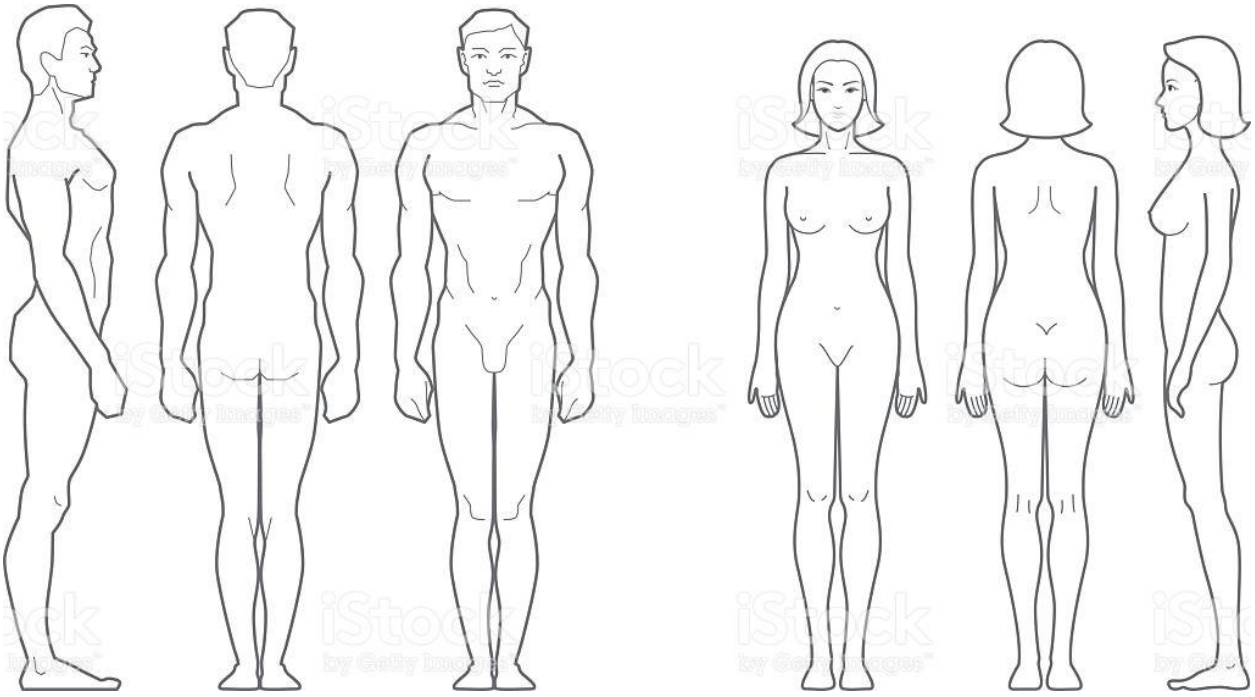
_____
_____
_____
_____
_____

Describe what makes your conditions **better/ worse** or other areas of concern you would like to address:

_____
_____
_____

Please indicate where your symptoms are occurring and/or any other areas of pain, tenderness, burning, numbness, tingling, stiffness, swelling, etc..

Males **Females**



Allergies/ Intolerances: (Drugs, environmental, chemical, foods, etc.,):_____
_____

Medications currently taking (Names & Dosages): please attached additional page if necessary: _____

_____
_____

Vitamins/ Supplements/ Herbs: _____

_____

Exercise (days per week, length of workout, type of activity): _____

_____

Diet (meals per day, diet plans, snacks): _____

_____

Do you **smoke**? _____ Do you drink **alcohol**: _____

If **yes** to either/both, how much? _____

Personal History: please check any conditions you have now or have had in the past.

- ☐ Anxiety
- ☐ Cancer
- ☐ Arthritis
- ☐ Depression
- ☐ Chronic Pain
- ☐ Asthma
- ☐ Other:

- ☐ Anemia
- ☐ Seizures/Epilepsy
- ☐ Hypo/Hyperglycemia
- ☐ Thyroid disorder
- ☐ Hepatitis
- ☐ Infertility

- ☐ Heart disease
- ☐ Kidney issues
- ☐ Stroke/ TIA
- ☐ Gastritis
- ☐ Diverticulitis
- ☐ IBS

- ☐ Hypogonadism
- ☐ Diabetes
- ☐ Gout
- ☐ Eating disorder
- ☐ Alcoholism
- ☐ Hypertension

Please describe: _____

Family Medical History: F (father); M (mother); S (sister); B (brother); GM (grandmother); GF (grandfather)

- ☐ Diabetes: ____
- ☐ HTN: _____
- ☐ Seizures: _____
- ☐ Cancer: _____
- ☐ Heart dx: _____
- ☐ Asthma: _____
- ☐ Stroke: _____
- ☐ Other: _____

Please describe: _____

Range of Systems

Please take your time and check if you have had any of these items listed below in the last year, or if you feel they are a significant part of your medical history:

General

- ☐ Poor Appetite
- ☐ Chills
- ☐ Night sweats
- ☐ Sweats easily
- ☐ Poor Sleep
- ☐ Cravings
- ☐ Weight gain
- ☐ Poor balance
- ☐ Fatigue
- ☐ Bruise easily
- ☐ Weight loss
- ☐ Tremors
- ☐ Fevers
- ☐ Muscle weakness
- ☐ Energy loss
- ☐ Appetite change

Skin & Hair

- ☐ Rashes
- ☐ Dermatitis
- ☐ Warts
- ☐ Fungal infection
- ☐ Moles
- ☐ Eczema
- ☐ Ulcerations
- ☐ Hives
- ☐ Skin changes
- ☐ Itching
- ☐ Psoriasis
- ☐ Dandruff
- ☐ Allergic reaction
- ☐ Hair changes
- ☐ Brittle nails
- ☐ Skin discoloration
- ☐ Acne
- ☐ Hair loss
- ☐ Facial flushing
- ☐ Skin tears

Head/ Eyes, Ears, Nose, Throat

- ☐ Dizziness
- ☐ Eye pain
- ☐ Cataracts
- ☐ Sinus issues
- ☐ Mouth sores
- ☐ Trouble swallowing
- ☐ Poor vision
- ☐ Poor hearing
- ☐ Recurrent colds
- ☐ TMJ
- ☐ Headaches
- ☐ Color blindness
- ☐ Ringing in ears
- ☐ Facial pain
- ☐ Dry mouth
- ☐ Eye Strain
- ☐ Blurred vision
- ☐ Earaches
- ☐ Nose bleeds
- ☐ Excess saliva

Cardiovascular

- ☐ Chest pain
- ☐ Cold feet/hands
- ☐ Shortness of breath
- ☐ Irregular heart beat
- ☐ Feet swelling
- ☐ High blood pressure
- ☐ Palpitations
- ☐ Blood clots
- ☐ Low blood pressure
- ☐ Fainting
- ☐ Phlebitis
- ☐ Dizziness

Respiratory

- ☐ Cough
- ☐ Wheezing
- ☐ Asthma
- ☐ Bronchitis
- ☐ Pneumonia
- ☐ Pain w/breathing
- ☐ Chest tightness
- ☐ Trouble Breathing

Gastrointestinal

- ☐ Nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Gas
- ☐ Belching
- ☐ Black stools
- ☐ Blood in stool
- ☐ Indigestion
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Bloating
- ☐ Abdominal pain
- ☐ Acid reflux/GERD
- ☐ Hernia
- ☐ Excessive thirst
- ☐ Appetite change
- ☐ Increased appetite
- ☐ Decreased appetite

Genito-Urinary

- ☐ Pain with urination
- ☐ Frequent urination
- ☐ Urinary urgency
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ UTI
- ☐ Impotence
- ☐ Testicle pain
- ☐ Testicle mass
- ☐ Genital sores
- ☐ Prostatitis
- ☐ Night-time urination

Gynecological/ Reproductive

- ☐ Painful intercourse
- ☐ Ovarian cysts
- ☐ Endometriosis
- ☐ Painful menstruation
- ☐ PMS
- ☐ Uterine fibroids
- ☐ Vaginal discomfort
- ☐ Vaginal dryness

Musculoskeletal

- ☐ Neck pain
- ☐ Shoulder pain
- ☐ Hand/wrist pain
- ☐ Carpal Tunnel
- ☐ Knee pain
- ☐ Sprains
- ☐ Sciatica
- ☐ Foot/ankle pain
- ☐ Hip pain
- ☐ Muscle pain
- ☐ Muscle weakness
- ☐ Tendonitis
- ☐ Bursitis
- ☐ Low back pain
- ☐ Mid-back pain
- ☐ Upper back pain

Neuropsychological

- ☐ Seizures
- ☐ Gait imbalance
- ☐ Vertigo
- ☐ Dizziness
- ☐ Numbness
- ☐ Anxiety
- ☐ Panic attacks
- ☐ Stressed
- ☐ Nervousness
- ☐ Irritability
- ☐ ADD/ADHD
- ☐ Depression

Please further describe any of the boxes checked as you deem necessary. Also, describe any other areas of concern that you would like to address: _____

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

HIPAA Privacy Practices Acknowledgement Form

Due to HIPAA laws and regulations, we as a healthcare provider are required to provide you with a Notice of Privacy Practices that describes your rights as a patient and must document that every patient/ client has read and received it. The form is found on our website and always available at our office.

By signing below, I acknowledge the receipt of the Notice of Privacy Practices at Grandview Primary Care & Performance Medicine Institute.

Printed Name: _____

Signature: _____ Date: _____