Animas Laser Therapy

48 County Road 250
Suite #6
Durango, CO. 81301

altdurango.com
(970) 422-8510
Find us on

Thank you for taking the time to fill out this overview form. This information will greatly assist us in helping you achieve your health and wellness goals. ***All information is strictly confidential.***

Intake Form

Name: _____ Date: _____ Date of Birth: _____

Address: _____

Email: _____ Occupation: _____ Age:_____

.....

Would you like to be on our email list? Y N *(Your information will never be given to any other person or business.)*

Telephone Home: _____ Work: _____ Mobile: _____

Emergency Contact Name: _____ Phone: _____ Relation: _____

Spouse/Partner Name: _____

How did you hear about Animas Laser Therapy? _____

Other healthcare providers:

1. Name: _____
   Profession: _____
   Phone: _____

2. Name: _____
   Profession: _____
   Phone: _____

3. Name: _____
   Profession: _____
   Phone: _____

4. Name: _____
   Profession: _____
   Phone: _____

Health Information

Please list your health concerns (physical, emotional, or psychological) in order of importance to you, and the date of onset:

1. _____ _____

2. _____ _____

3. _____ _____

4. _____ _____

5. _____ _____

Anything further: _____

Please list your most stressful life experiences (physical or psychological):

1. _____ Age: _____

2. _____ Age: _____

3. _____ Age: _____

4. _____ Age: _____

5. _____ Age_____

Anything further: _____

Supplements & Drug Medications

Please list all **current** vitamins/minerals, herbs, or homeopathic remedies.

Supplement	Dose/day	How long	Reason for Supplement

Please list all **current** medications (prescription and over-the-counter).

Medication	Dose/day	How long	Reason for Medication

Are the medications well tolerated? Y N If no, please list the adverse reactions or side effects and from what medication:

_____

_____

In the last 10 years, approximately how many **courses of antibiotics** have you taken? _____

Medical History

Please indicate if you have had any of the following diagnostic tests performed:

Test	Notable finding	Test	Notable finding
☐ Thyroid Panel	_____	☐ Cholesterol	_____
☐ Liver Panel	_____	☐ Hormone level	_____
☐ Complete blood count	_____	☐ EKG	_____
☐ Blood sugar test	_____	☐ Chest x-ray	_____
☐ Colonoscopy	_____	☐ Mammography	_____
☐ Food Allergy	_____	☐ Thermography	_____
☐ Heavy Metals	_____	☐ Adrenal Function	_____
☐ Digestive Stool Analysis	_____	☐ other	_____

Date and findings of last **physical exam**:

_____

_____

Please list any past **surgeries or hospitalizations**: Date:

_____ _____

_____ _____

_____ _____

Please list all **past injuries** (ie. broken bones, joint sprains, burns, falls, car accidents, etc.): Date:

_____ _____

_____ _____

_____ _____

List all **dental work** (root canal, mercury or ceramic filling, implants, caps, dentures): Date:

_____ _____

_____ _____

_____ _____

Check all that apply:

Childhood Illness

- ☐ Asthma
- ☐ Chickenpox
- ☐ Eczema
- ☐ Frequent ear infections or colds
- ☐ Measles
- ☐ Mumps
- ☐ Polio
- ☐ Rubella
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Whooping cough

Vaccination History

- ☐ Measles
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Tetanus
- ☐ Small pox
- ☐ Diphtheria
- ☐ Mumps
- ☐ Flu Shot
- ☐ Chicken pox
- ☐ Pertussis
- ☐ Rubella
- ☐ Polio
- ☐ Shingles

Other Medical Procedures

- ☐ Joint replacement
- ☐ Pacemaker
- ☐ Pins or plates

What is your **blood type**? A+ B+ O+ AB+ A- B- O- AB-

Height:_____ Current Weight:_____ Ideal Weight:_____ Weight 1 yr. ago:_____ Max weight:_____ When:_____

Review of Systems

Circle if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past**.

General	weight gain weight loss history of dieting	chronic fatigue weakness excessive thirst anemia	spontaneous swelling night sweats fever/chills sick more than 1 time / yr	intolerance to heat intolerance to cold cold hands/feet other:
Skin	dry skin itchy skin rashes/hives moist skin bruise easily	acne eczema psoriasis shingles ringworm	athlete's foot moles bumpy skin on back of arms spider/varicose veins	changes to nails changes to skin color changes to moles nail fungus other:
Head	headaches migraines	dizziness vertigo	trauma hair loss	other:
Eyes	dry eyes watery eyes itchy eyes eye pain red eyes discharge from eyes	floaters/hallo/flashes blurred vision impaired vision double vision sensitive to light poor night vision	sties cataracts vision loss other	vision correction: _____ vision: near or far contacts: glasses: laser:
Ears	ear pain itchy ears waxy ears	discharge from ears ringing in ears hearing loss	ear infections ear infections as a child	hearing aids other:
Nose & Sinuses	itchy nose nasal discharge congested nose/sinuses	postnasal drip nosebleeds loss of smell	breathe through mouth snores	other:
Mouth & Throat	Dry mouth itchy mouth/throat sores on mouth/lips hay fever/allergies bad breath root canals	frequent sore throat coughing up blood persistent cough difficulty swallowing loss of taste hoarseness	dentures inflamed/bleeding gums cavities braces teeth sensitivity	jaw clicks TMJ Other:
Neck	neck pain or stiffness	swollen glands	trauma	other:
Respiratory	shortness of breath wheezing pain with breathing chronic cough coughing up blood	asthma allergies bronchitis/pneumonia positive TB test history of smoking	exposure to chemicals exposure to solvents exposure to particulates	history of 2nd hand smoke other:
Cardiovascular	high blood pressure low blood pressure high cholesterol high glucose chest pain	feel heart racing chest tightness difficulty breathing at night palpitations swelling in ankles heart fluttering	purple fingers/lips irregular heartbeat heart murmur dizziness on standing exhaustion with minor exertion	varicose veins hemorrhoids spider veins calf pain at night calf pain walking other:

Circle if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past**.

Gastrointestinal	poor appetite excessive appetite changes in appetite excessive thirst trouble swallowing stomach pain nausea / vomiting vomit blood burping / belching abdominal pain abdominal bloating gas / flatulence	indigestion heartburn / antacid use constipation (<1 stool/day) stool hard to pass diarrhea blood in stools black tar in stools mucous in stools undigested food in stools	fatigue after eating food sensitivity anal itching liver disease gallbladder disease treated for parasites ulcers hemorrhoids	intolerance to specific foods: Other:
Endocrine	hypothyroid hyperthyroid hypoglycemia excessive thirst	heat or cold intolerance diabetes fatigue	poor appetite excessive hunger seasonal depression	weight loss weight gain other:
Immune	slow wound healing reactions to vaccinations	chronic fatigue syndrome	chronically swollen glands	chronic infections other:
Neurological	fainting dizziness / vertigo numbness or tingling trembling hands	head trauma poor concentration memory loss lack of alertness	loss of grip strength loss of muscle tone muscle weakness heavy head heavy extremities	other:
Urinary	frequent urination urinate <3 times/day can't hold urine urination with cough or sneeze	light yellow urine dark yellow urine yellow urine red urine cloudy urine strong smelling urine	kidney infections bladder infections urination at night pain/burning urination	dripping after urination bed-wetting other:
Musculoskeletal	pain in: - arms - hands - shoulders - neck - upper back - lower back - hips - legs - feet	painful bones tight shoulder muscles swollen knees/elbows numbness / tingling burning spasms/cramps morning stiffness	chronic pain loss of height unable to sit straight activities limited due to pain	arthritis herniated/slipped disk tendonitis osteoporosis broken bone other:

Circle if the symptom has occurred in the **last year**. Place a **check mark** if the symptom has occurred in the **past**.

Women only	age of first menses:_____ length of period:_____ length of cycle:_____ date of last menses:_____ heaviest flow day:_____ abnormal pap	# pregnancies: _____ # live births:_____ sexually active Y N With whom are you sexually active?: -men - women - both type of birth control: type of STD control: -condoms - monogamy -other:	-spotting between periods -clots with period -menstrual cramps -weight gain with period -PMS -irritability -moodiness -crave sweets -tendency to cry -bloating / swelling -breast tenderness -low back pain -fatigue with period -missed periods -irregular periods -difficulty conceiving -lack of sexual desire	-vaginal itching -vaginal discharge -vaginal odor -yeast infections -dry vaginal mucosa -painful intercourse -history of STDs: Y N -tested for STDs: Y N -uterine cyst/fibroids -hysterectomy -use of birth control pill for greater than 10 yrs?
Women only	monthly breast self-exam Y N fibrous breast breast feed your child breast implants history of mammograms abnormal mammogram nipple discharge	hot flashes changes in cycle brain fog menopause age of menopause: _____	use of hormone replacement:	other:
Men only	sense of full bladder difficulty urinating burning/pain with urination wake up to urinate dripping after urination increased straining w urination	discharge from penis sore on penis history of STDs Y N tested for STDs Y N premature ejaculation painful ejaculation erectile dysfunction infertile lack of sexual drive sexual difficulties	testicular lump testicular pain monthly testicular self-exam? Y N history of prostatitis enlarged prostate prostate exam? Y N PSA test? Y N prostate cancer pain/cold in genital area hernias	currently sexually active? Y N with whom are you sexually active?: - men - women - both type of birth control: type of STD control: -condoms -monogamy -other:
Emotional	depression mood swings	treated for emotions tension	suicidal thoughts anxiety / nervousness	other:

Family History

*Please indicate whether any **family members** have had any of the following: (Include parents, siblings, maternal grandparents (MGP), paternal grandparents (PGP), aunts, uncles. Include age and cause of death if applicable.)*

	Relation to you		Relation to you
☐ Alcoholism	_____	☐ Diabetes	_____
☐ Allergies	_____	☐ Drug abuse	_____
☐ Alzheimer's Disease	_____	☐ Heart Disease	_____
☐ Arthritis	_____	☐ High Blood Pressure	_____
☐ Asthma	_____	☐ Kidney disease	_____
☐ Cancer (indicate type)	_____	☐ Osteoporosis	_____
☐ Depression	_____	☐ Stroke	_____
☐ Epilepsy	_____	☐ Thyroid condition	_____
☐ Autoimmune condition	_____	☐ Anemia	_____
☐ Skin condition	_____	☐ Glaucoma	_____
☐ Tuberculosis	_____	☐ Other medical illness	_____

Activities of Daily Living

Please check all that apply and specify frequency/amount.

- ☐ Caffeine:_____
- ☐ Soda:_____
- ☐ Alcohol:_____
- ☐ Recreational Drugs:_____
- ☐ Tobacco:_____
- ☐ Red Meat:_____
- ☐ Hours of sleep per night:_____
- ☐ Difficulty sleeping:_____
- ☐ Physical Activity:_____
- ☐ Chemical Exposure:_____
- ☐ Number of meals per day:_____
- ☐ Water consumption per day:_____
- ☐ Social Support:_____

Please list all allergies (food, medication, environmental):

_____

_____

_____

Please describe the emotional climate of your home:

_____

_____

_____

Rate your stress level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

Which factors most contribute to your stress?

☐ health ☐ work ☐ money ☐ family ☐ marriage ☐ other

Please describe: _____

_____

_____

What brings you joy? _____

_____

Any additional information about your health that you would like to share: _____

_____

_____

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