NANCY BURKE CST
4515 San Pablo Dam Rd. #1, El Sobrante, CA 94803
510.236.1007

INTAKE FORM FOR NANCY BURKE CST

NAME:_____

ADDRESS:_____

CITY,STATE, ZIP CODE,:_____

HM PHONE : _____WK PHONE : _____EMAIL:_____

BIRTH DATE : _____ AGE : _____ SEX : □ female □ male

HEIGHT : _____ WEIGHT : _____

OCCUPATION : _____ □ full time □ part time

REFERRED BY/HOW YOU HEARD ABOUT ME

_____

When, where, and by whom did you receive your last medical or health care?

_____

_____

What are your most important health concerns? List in order of importance.

1. _____
2. _____
3. _____
4. _____
5. _____

What prescription or over-the-counter medications, herbs, vitamins, or supplements are YOU taking? Please list.

_____

_____

MEDICAL HISTORY Please check the boxes that apply

CURRENT	PAST	
☐	☐	Allergies
☐	☐	Anemia
☐	☐	Arthritis
☐	☐	Asthma
☐	☐	Alcoholism
☐	☐	Bleeding
☐	☐	Cancer
☐	☐	Candida (yeast)
☐	☐	Diabetes
☐	☐	Digestive Problems
☐	☐	Fainting
☐	☐	Gout
☐	☐	Headaches
☐	☐	Heart Disease/Heart Problems
☐	☐	Hepatitis
☐	☐	Hypertension (High blood pressure)
☐	☐	Imunodeficieny Disorders

CURRENT	PAST	
☐	☐	Insomnia
☐	☐	iver disease/jaundice
☐	☐	OB/Gyn Problems
☐	☐	Pneumonia
☐	☐	Prostate Disorders
☐	☐	Skin Problems
☐	☐	Thyroid Problems
☐	☐	Ulcers
☐	☐	Other (specify) _____

Such as broken bones or injuries to your spine.

HOSPITALIZATIONS

Please list illness or operation/procedure and date.

_____

Are you allergic to any medicines or other substances? Please list.

_____

WOMEN ONLY (answer even if you are no longer menstruating)

At what age did you start menstruating? _____

Length of cycle (first day is the day you start bleeding, last day is the day before you start bleeding again) _____

Length of period (number of days you bleed) _____

Date of last menstrual period _____

WOMEN ONLY (answer even if you are no longer menstruating)

Amount	Scanty	Excessive		Moderate
Color	Dark red	Pale red		Red
Clotting	No	Yes		
Breast tenderness	No	Yes, list when		
Bloating	No	Yes, list when		
Mood swings	No	Yes, list when		
Food cravings	No	Yes, list when & what		
Cramps	No	Yes		
If cramps, when	Before bleeding	1st day	During	After
What alleviates the pain ?				
What aggravates the pain ?				
Headaches with period?				

Are you pregnant? ☐ NO ☐ YES

Are you trying to get pregnant? ☐ NO ☐ YES

Have you ever been pregnant? ☐ NO ☐ YES

If you have been pregnant, list number of pregnancies and outcome

Year Outcome (live birth, still born, miscarriage, abortion, ectopic

____ _____

____ _____

____ _____

____ _____