

**Patient Intake Form**

Name \_\_\_\_\_

Date \_\_\_\_\_

DOB \_\_\_\_\_

Age \_\_\_\_\_

Phone \_\_\_\_\_

Address \_\_\_\_\_

\_\_\_\_\_

\_\_\_\_\_

Email \_\_\_\_\_

Please describe the reason(s) for wanting to work with Dr. Lucille:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please share what you would like to change about your health and wellness:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe any past health issues, hospitalizations or illnesses:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list and describe all family medical history:

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please list:

Other practitioners seen or seeing

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Specific treatment/testing done  
(Include results if available)

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Any medication you are currently taking: dosage, how long and reason prescribed

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Any supplements you are currently taking, brand, dosage, and for what reason

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Please share aspects of you life:

**SLEEP**

How many hours per night do you sleep? \_\_\_\_\_

What is the quality of your sleep \_\_\_\_\_

Do you have trouble falling asleep?      Y      N

Do you have trouble staying asleep?      Y      N

Do you wake feeling rested?      Y      N

**ENERGY**

Describe you energy throughout the day \_\_\_\_\_

Do you ever "borrow" energy from caffeine or sugar during the day?      Y      N

Do you fell calm at the end of your day?      Y      N

**STRESS**

Please describe the role stress play in your life, both historically and currently

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Have you ever had periods of extreme and chronic stress?      Y      N

If yes, please  
explain \_\_\_\_\_

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How do you feel you handle stress?

Explain how you cope with stress

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**SOCIAL HISTORY**

|   |   |   |
|---|---|---|
| Do you have supportive relationships in your life?          | Y | N |
| Do you use alcohol? If so, what do you drink and how often? | Y | N |
| Do you use caffeine? If so, what and how often?             | Y | N |
| Do you use or have you ever used drugs?                     | Y | N |
| Do you use tobacco products? If so, how often and how long? | Y | N |

**DIET**

Please use the space below to describe what your relationship with food has been like over your lifetime, up to the present. Then, provide a 24-hour recall of what you have eaten and drank, including portions and times.

Thank you, so much for sharing, is there anything else you would like Dr. Lucille to know?

\_\_\_\_\_Signature \_\_\_\_\_Date