

**PINE TREE CLINIC FOR COMPREHENSIVE MEDICINE**

**ROBERT ZIEVE, MD**

**INTAKE FORM**

**This form must be completed in entirety before your initial consultation.  
The only exception is an emergency initial consultation.**

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Tel. No.: Home: \_\_\_\_\_ Work: \_\_\_\_\_ Cell: \_\_\_\_\_

E-mail address: \_\_\_\_\_

Age: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ Gender: female \_\_\_\_\_ male \_\_\_\_\_

Education: \_\_\_\_\_

Married: \_\_\_\_\_ Separated: \_\_\_\_\_ Divorced: \_\_\_\_\_ Widowed: \_\_\_\_\_ Single: \_\_\_\_\_ Partnership: \_\_\_\_\_

Live with: Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Parents \_\_\_\_\_ Children \_\_\_\_\_ Friends \_\_\_\_\_ Alone \_\_\_\_\_

Occupation: \_\_\_\_\_ House per week: \_\_\_\_\_ Retired: \_\_\_\_\_

Employer: \_\_\_\_\_ S.S. #: \_\_\_\_\_

Work Address: \_\_\_\_\_

How did you hear about our clinic? \_\_\_\_\_

\_\_\_\_\_

Has any other family member already been a patient at the clinic? \_\_\_\_\_

\_\_\_\_\_

Next of kin or other to reach in an emergency: \_\_\_\_\_

Relationship: \_\_\_\_\_ Phone: \_\_\_\_\_

Address: \_\_\_\_\_

\_\_\_\_\_

What are your most important health problems? List up to five in order of importance that you want to address:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Please write a one page summary of the central issues that you want to address with me and the history behind them. This is mandatory to bring with you for the first visit.**

Do you have any known contagious diseases at this time?    Y    N

If yes, what? \_\_\_\_\_

### **ALLERGIES**

Are you hypersensitive or allergic to...

Any drugs? \_\_\_\_\_

Any foods? \_\_\_\_\_

Any environmentals or chemicals? \_\_\_\_\_

Allergic to or have problems with Procaine or Dental anesthetics?

Yes     No     Don't know

Are you currently receiving healthcare?    Y    N

If yes, where and from whom: \_\_\_\_\_

\_\_\_\_\_

If no, when and where did you last receive medical or health care? \_\_\_\_\_

\_\_\_\_\_

What was the reason? \_\_\_\_\_

**Current Pharmaceutical Medications**

Do you take or use:

Laxatives	Y N	Pain Relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list any prescription medications and over the counter medications.

1. \_\_\_\_\_ 4. \_\_\_\_\_  
2. \_\_\_\_\_ 5. \_\_\_\_\_  
3. \_\_\_\_\_ 6. \_\_\_\_\_

**Vitamins and Supplements**

Please list any vitamins or other supplements you are taking? Please write brand name next to supplement.

1. \_\_\_\_\_ 5. \_\_\_\_\_  
1. \_\_\_\_\_ 5. \_\_\_\_\_  
1. \_\_\_\_\_ 5. \_\_\_\_\_

**General**

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ lbs. Weight 1 year ago: \_\_\_\_\_ lbs.

When during the day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

**Typical Food Intake**

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

To drink: \_\_\_\_\_

**Miscellaneous**

Alcohol intake: \_\_\_\_\_ Tobacco: \_\_\_\_\_

Caffeine: \_\_\_\_\_ Recreational drugs: \_\_\_\_\_

Describe  
cravings \_\_\_\_\_

Fears past  
and present: \_\_\_\_\_

Recurring  
dreams: \_\_\_\_\_

<b>Vaccination history</b>	<b>Date</b>	<b>Reaction to Vaccination? Please describe:</b>
DPT (Diphtheria, Pertussis, Tetanus)	_____	_____
MMR (Measles, Mumps, Rubella)	_____	_____
Small Pox	_____	_____
Chicken Pox	_____	_____
Hepatitis A	_____	_____
Hepatitis B	_____	_____
Flu Vaccine	_____	_____
Polio	_____	_____
Other:	_____	_____

**Vaccinated in Military Service:**       Yes       No

**Surgery history — Please List All Surgeries**

**Age**

**Complications?**

**REFER TO LIST BELOW**

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**List of Common Surgeries:**

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|--|---|--|---|--|
| <ul style="list-style-type: none"> <li>• Adhesion</li> <li>• Amputation</li> <li>• Apnea Surgery</li> <li>• Appendectomy</li> <li>•</li> <li>• Ear (Tubes, Elective, Endocrine Surgery, Thyroidectomy, Parathyroidectomy)</li> <li>• Brain Surgery</li> <li>• Breast (Implants, Biopsy, Reduction)</li> <li>• Bunionectomy</li> <li>• Caesarian Section (C-Section)</li> <li>• Cholecystectomy (Removal of part of the Colon)</li> <li>• Cosmetic Surgery (Implants, Injections, other)</li> <li>• Dilatation and Curettage (D&amp;C)</li> </ul> | <ul style="list-style-type: none"> <li>• Episiotomy (Pelvic Floor before Childbirth)</li> <li>• Gastroesophageal Reflux</li> <li>• Hair Transplant</li> <li>• Heart Surgery</li> <li>• Joint Surgery (Knee, Shoulder, Fingers, Hand, Feet, Hip)</li> <li>• Hemorrhoidectomy</li> <li>• Hernia Surgery</li> <li>• Hydrocele</li> <li>• Hysterectomy (Abdominal, Vaginal, Total, Partial)</li> <li>•</li> </ul> | <ul style="list-style-type: none"> <li>• Laparoscopy or Laparoscopic Surgery (Abdominal, Pelvic, Hernia Repair, Gall Bladder...)</li> <li>• Liposection</li> <li>• Mastectomy</li> <li>• Oncology Surgery (Cancer)</li> <li>• Oral Surgery (Uvuloplasty, Tonsillectomy)</li> <li>• Adenoid Removal, Implant, Extraction, Jaw, Gum, Wisdom Teeth, Removal)</li> <li>• Peripheral Vascular Surgery (Bypass, Stint)</li> <li>• Plastic Surgery (Face Lift, Eye Lift, Chin Lift, Brow Lift, Nose, Rhinoplasty, Implants, Liposection, Tummy Tuck, Collagen Injections, Botox)</li> </ul> | <ul style="list-style-type: none"> <li>• Reconstructive Surgery (For Ccongenital Defects, Scar Tissue, Due to Trauma)</li> <li>• Scar Revision</li> <li>• Skin (Grafts, Warts, Moles, Biopsy, Cut, Frozen, Burned, Skin Tag)</li> <li>• Snoring Surgery (Uvulaectomy)</li> <li>• Tummy Tuck</li> <li>• Varicose Veins</li> <li>• Varicocele Repair</li> <li>• Spine Surgery (Back, Neck, Tailbone)</li> <li>• Tubal Ligation</li> <li>• Sports Surgery (From Injury)</li> <li>• Vasectomy</li> <li>• Vasectomy Removal</li> </ul> | <p><b>Dental Surgeries</b></p> <ul style="list-style-type: none"> <li>• Implants</li> <li>• Root Canals</li> <li>• Jaw</li> <li>• TMD/TMJ</li> <li>• Reconstruction</li> <li>• Palate</li> <li>• Gum</li> <li>• Roof of Mouth</li> <li>• Tonsils</li> <li>• Adenoids</li> <li>• Tongue</li> <li>• Piercing</li> <li>•</li> </ul> |
|--|---|--|---|--|

**Injuries / Accidents Without Stitches**

**Age**

**REFER TO LIST BELOW**

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**List of Common Injuries Without Stitches:**

- |  |   |   |  |   |
|--|---|---|--|---|
| <ul style="list-style-type: none"> <li>• Head Trauma</li> <li>• Major Falls</li> </ul> | <ul style="list-style-type: none"> <li>• Broken Bones</li> <li>• Tailbone Injuries</li> </ul> | <ul style="list-style-type: none"> <li>• Concussion</li> <li>• Other</li> </ul> | <ul style="list-style-type: none"> <li>• Contusions</li> </ul> | <ul style="list-style-type: none"> <li>• Fractures</li> </ul> |
|--|---|---|--|---|

**Scars — Please list all scars**

**Age**

**Stitches?**

**REFER TO LIST BELOW**

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Yes     No

Yes     No

Yes     No

Yes     No

Yes     No

**List of Common Scars:**

- Scars, Sports Injuries
- Piercings
- Keloids
- Hypertrophic Scars
- Contractures
- Acne
- Chicken Pox
- Hit With Rock
- Small Pox Vaccines
- Vaccination with Multi-Dose Gun
- Cut with Glass
- Step On Nail
- Barbed Wire
- Cut With Knife
- Smashed with Hammer
- Splinter
- Ring Cut from Punch
- Split Lip
- Braces Cut Inside Mouth
- Face into Windshield of Car
- Burns
- Sunburns
- Wounds
- Scrapes
- Tattoos
- Scarification
- Pinched

**Chronic and repeating problems**

**Age**

**REFER TO LIST BELOW**

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**List of Common Chronic And Repeating Problems:**

- Urinary Tract Infections
- Yeast Infections
- Pneumonia
- Asthma
- Bowel Problems (Diarrhea, Constipation, Irritable Bowel, Colitis)
- Headaches
- Pains that Come and Go (Give the Location)
- Back Pain
- Back Problems
- Joint Pain
- Tooth Pain
- Colds
- Tooth Problems
- Sciatica
- Flu
- Stomach Pain
- Pain
- Cough
- Bronchitis

## Psychological Traumas/Addictions

Age

REFER TO LIST BELOW

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### List of Common Psychological Traumas/Addictions:

- Psychological Traumas: Abuse
- Rape
- Childhood Spanking
- Divorce
- Frequent Arguments
- Difficult or Abusive Relationships
- Slow or Late Onset of Puberty
- Suicide Attempts (PTSD) Post Traumatic Stress Disorder
- Stress
- Burnout
- Eating Disorders
- Grief
- Loss
- ADD
- ADHD
- Anxiety
- Depression
- Addictions
- War
- Shock

## Pelvic History (Births, STD's, etc)

Age

REFER TO LIST BELOW

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### List of Common Pelvic Histories:

- Childbirth
- Sexually Transmitted Diseases
- Gonorrhea
- Syphilis
- Warts
- Herpes
- Chlamydia
- Yeast Infections
- (PID) Pelvic Inflammatory Disease
- Fibroids
- Irregular Periods
- Infertility
- BPH (Enlarged Prostate)
- Prostatitis
- Frequent Sexual Partners
- Many Sexual Partners
- Erection Difficulties (Pain, Impotence, Scarring)
- Decreased Sexual Desire
- Few or No Orgasms
- Painful Orgasms
- Painful Sexual Relations
- No Difficulties and Enjoyable Sexual Relations

## Toxic Materials Exposure

Age

REFER TO LIST BELOW

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### List of Common Toxic Materials Exposure:

- Agriculture
- Art
- Asbestos
- Auto manufacturing
- Auto repair
- Auto body
- Chemicals
- Construction
- Dentist
- Dissection
- Dry cleaning
- Electronics
- Farming
- Foundry
- Hairdressing
- Mining
- Mortician
- Painting
- Pesticides
- Photography
- Photocopy business
- Pottery
- Printing
- Printmaking
- Plastics
- Ship repair
- Silk screening
- Staining
- Work in buildings where windows don't open (sick building syndrome)
- EMF (Electromagnetic Frequencies from cell phones, Cell phones, Cell towers, Computers, Stove, Refrigerators, Cars, Clock radios and all electrical appliances and bulbs that are not shielded)

## Sensitivities (Medication, Food, EMF)

Age

REFER TO LIST BELOW

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- Allergies (Medication)
- Food
- Nutrients
- Pollen
- Other: Drugs of any kind
- Hayfever
- Wheat
- Dairy
- Corn
- Eggs
- Soy
- Peanuts
- Seafood
- Strawberries
- Latex
- Animal Fur
- Odors
- Skin
- Seasonal
- Bee Sting
- Insect Bites
- Mold
- Airborne
- Dust Mites
- Chemicals
- Food Colorings
- Food Preservatives
- Semen
- Contraceptive Foams
- Contraceptive Jellies
- Contraceptive Creams
- Contraceptive Lubricants

**Travel or Live Outside of USA**

**Age**

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**Travel or Live Outside of USA:** This helps to understand what you have been exposed to on different Continents.

**Treatment for Parasites:**

Yes

No

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**MEDICAL HISTORY:**

For each person below, follow the line across the page and enter their age and mark an X in those boxes which indicate their present state of health (good), (poor), or write in the cause and age at death. Then place an X in those boxes which correspond with any illnesses that they have ever had.

	Age	Health		Cause and age at death	Alcohol/drug addiction	Allergies or asthma	Anemia	Diabetes	Cancer or tumor	Epilepsy	Genetic disease	Heart trouble	Herpes	High blood pressure	Kidney or bladder trouble	Mental disorder	Rheumatism	Stomach/intestinal trouble	Thyroid disease	Tuberculosis	Gonorrhea/syphilis	
		Good	Poor																			
Self:																						
Father:																						
Mother:																						
Brothers or Sisters:																						
Mother's Mother:																						
Mother's Father:																						
Mother's Relatives, Other:																						
Father's Mother:																						
Father's Father:																						
Father's Relatives, Other:																						

**Homeopathy** — Do any of the following describe you or how you feel? Please **check the boxes that apply** and if possible indicate by a star which is the strongest for you

	<b>A.</b> The feeling is of an acute threat and the reaction is strong and instinctive. You must struggle in order to recover or maintain your position.	<b><i>Panic.</i></b>
	<b>C.</b> There is a feeling of weakness and incapacity within, and the need to perform exceedingly well and live up to very high expectations. The reaction is a superhuman effort, stretching beyond the limits of your capacity. It is continuous, prolonged struggle which seems to have no end. Your survival depends on it, for failure would mean death and destruction.	<b><i>Perfection.</i></b>
	<b>L.</b> The feeling is of intense oppression, intense hopelessness, isolation and an intense desire for change.	<b><i>Isolation.</i></b>
	<b>M.</b> There is an acute feeling of threat that comes up intermittently, in phases, between which there is an underlying chronic, fixed feeling of being deficient. This is characterized by sudden, acute manifestations that come up from time to time, followed by periods of quiescence.	<b><i>Periodic.</i></b>
	<b>P.</b> The feeling is that of a difficult situation where one has to struggle in order to succeed. There is anxiety with doubts about your ability, but you are hopeful and failure does not mean the end of the world.	<b><i>Struggle.</i></b>
	<b>R.</b> It is characterized by an alternation between periods of struggle with anxiety about success, and periods of despair and giving up.	<b><i>Trying.</i></b>
	<b>S.</b> The feeling is that you are faced with a situation beyond salvage, leading to complete hopelessness and despair. In a desperate effort, you try to change the situation and the result is usually destruction.	<b><i>Destruction.</i></b>
	<b>Sc.</b> The feeling is that there is a fixed, irremediable weakness within the self. The action is to attempt to cope with it and hide it from others; hence you cover it up with egotism, compulsive acts, are very secretive.	<b><i>Fixity.</i></b>
	<b>T.</b> The feeling is of intense oppression and a desire for change. The reaction is intense, hectic activity in order to break free from this oppression.	<b><i>Change.</i></b>
	<b>Ty.</b> The feeling is that of a critical situation which, if properly handled for a critical period, will end in total recovery. Your reaction is an intense struggle against it.	<b><i>Critical.</i></b>

**Dental Evaluation:**

Mercury silver fillings:

How many do you currently have? \_\_\_\_\_

How many have been removed in the past? \_\_\_\_\_

How many Root Canals do you have? \_\_\_\_\_

Wisdom teeth extractions: \_\_\_\_\_

Any bite or TMJ issues? \_\_\_\_\_

Any other dental issues? \_\_\_\_\_

**Is there anything else you would like to add or comment on?**

**Thank you for your time and effort. Our team looks forward to providing you with the best possible care.**