NEW PATIENT INTAKE FORM Melanie Gisler, DO

2211 Corinth Avenue, Suite 204
Los Angeles, CA 90064

Today's Date: _____

Patient Last Name | Patient First Name | Patient Middle Name

_____-_____-_____ Birth Date: _____
Social Security Number

_____
Email Address

Physical Street Address

Physical Address Line 2

City | State | Zip Code

Primary Phone Number | Cell Phone Number

_____
If Guardian Name and relation to patient

Gender (circle one) Male Female Other Marital Status _____

_____
Insurance Company Name

_____
Policy Holder's Name

_____
Insurance Policy Number | Insurance Group Number

_____
Primary Pharmacy Name | Primary Pharmacy Location

Primary Pharmacy Phone | Primary Pharmacy Fax

_____
Emergency Contact Name | Emergency Contact Phone

REFERRED BY

☐	Friend / Associate / Acquaintance	☐	Internet	☐	Conference
☐	Physician / Practitioner	☐	Flyer	☐	Other
☐	Therapist / Councilor	☐	Walk-in		

Please specify the name of the person who referred you or the Conference you attended

CONFIDENTIALITY AND FISCAL RESPONSIBILITY

Melanie Gisler, DO follows HIPPA guidelines. If you have not received a copy of the Notice of Privacy Practices explaining these guidelines and how we implement them, you may request one from our website www.drgisler.com.

☐ Check here to acknowledge that you have read our HIPPA guidelines and agree with our approach.

In addition to the HIPPA guidelines, Dr. Gisler practices and integrative approach to your complete health and recovery. While your privace and confidentiality is her highest priority, there are times when she may seek out the input and consultation of others involved in your health care including other past and present physicians, practitioners and therapists.

☐ Check here if you authorize Dr. Gisler to discuss your diagnosis and treatment protocols with others involved in your medical care.

☐ Check here if you DO NOT authorize Dr. Gisler to discuss your diagnosis and treatment protocols with others involved in your medical care.

Please read thoroughly and acknowledge that you will adhere to the following payment policies: 1. I am responsible for paying fees at the time of service. Accepted forms of payment are cash, personal checks, Visa, Mastercard and American Express. I will be responsible for a $25.00 service charge for insufficient funds. 2. I have provided credit card information and understand that I may be held responsible for a cancellation fee should I fail to cancel an appointment without 48 hour advance notice. 3. If I opt to submit insurance claims on my own behalf, I will be provided a Superbill to submit to my insurance company. 4. I understand that Supplements and Health Products are not included on Superbills and are not returnable. There may be a charge for prescription refills authorized or written at any and all times, other than a scheduled office visit.

This includes and prescription that needs to be called, faxed, or mailed. To avoid such charges, please present all your refill requests at the time of your visit with Dr. Gisler. The Prescription Refill Fee is $25.00 (1-4 Prescriptions)

☐ I have read and agree to the above terms and conditions.

_____ _____

Signature Date

HEALTH OBJECTIVES –

What is your primary goal regarding your health and well-being? What is it you most hope to achieve from your experience with Dr. Gisler?

MAJOR SYMPTOMS

Please list in order of priority the symptoms that are of concern to you.

Please let us know the degree to which you are distressed or experiencing pain in each of these areas:

	Mild	Moderate	Strong	Severe	Not Applicable
Head					
Arms					
Elbows					
Hands					
Wrists					
Torso					
Groin					
Upper Back					
Lower Back					
Upper Leg					
Lower Leg					
Knee					
Feet					
Ankle					

SYMPTOMS - Please check any and all of the symptoms that you are currently experiencing.

GENERAL:

Not sleeping well	Cravings	Hot Flashes
Fatigue	Weight Gain	Catch Colds Easily
Fevers	Weight Loss	Reactive to Tastes/Smells
Chills	Change in Appetite	Strong Thirst (hot or cold)
Excessive sweats	Localized Weakness	Fainting
Night Sweats	Poor Balance	Allergies
Tremors	Dizziness	Sudden fatigue
Poor Appetite	Bleed/Bruise Easily	Feelings of "heaviness"
Seizures	Seizures	

SKIN and HAIR

Rashes	Eczema	Heat Sensations in hands/feet/chest
Ulcerations	Pimples/Acne	Loss of hair (head/body)
Hives	Recent Moles	Dandruff
Skin Rashes	Dry Skin	Change in hair or skin texture
Itching	Skin Discoloration	Other Hair or Skin issue

SYMPTOMS - Please check any and all of the symptoms that you are currently experiencing.

HEAD, EYES, EARS, NOSE and THROAT

Dizziness	Color Blindness	Recurrent Sore Throat
Concussion	Cataracts	Frequent Ear Infection
Headaches	Blurry Vision	Bleeding, Swollen, Painful Gums
Frequent Headaches	Earaches	Dry Throat/Mouth/Nose
Migraines	Ringing in Ears	Bloodshot/Dry Eyes
Glasses	Poor Hearing	Facial Pain
Poor Vision	Nose Bleeds	Sores on Lips/Tongue
Eye Strain	Spots in front of Eyes	Grinding Teeth
Eye Pressure or Pain	See floating black spots	Teeth Problems
Night Blindness	Sinus Issues	Jaw Clicking

BEHAVIORAL:

Anxiety	Inability to Concentrate	Addiction / Substance Abuse
Panic Attacks	Anger/Rage	Paranoia
Poor Memory	Insomnia	Attention Deficit ADD/ADHD
Depression	Obsessive Compulsive Disorder	

MUSCULAR-SKELETAL:

Stiff Neck/Shoulders	Muscle Spasms	Sore/Cold/Weak Knees
Back Pain	Muscle Twitching	Food Pain
Low Back Pain	Muscle Cramping	Aching in Hands/Feet
Neck Pain	Joint Pain	

CARDIOVASCULAR:

Chest Pain	Fainting	Blood Clots
Irregular Heartbeat	Swelling of Hands	Phlebitis
Palpitation	Swelling of Feet	Difficulty Breathing
Dizziness	Cold Hands/Feet	Tight feeling in Chest
High Blood Pressure	Chronic Obstructive Pulmonary Disease	
Myocardial Infarction	Numbness of Hands and Feet	
Chronic Obstructive Pulmonary Disease	Any other Heart/Blood Vessel issue	
Chest Pain Radiating to Arms		

RESPIRATORY:

Cough, periodical	Bronchitis	Shortness of Breath, resting
Cough, persistent	Pneumonia	Shortness of Breath, exercising
Coughing Blood	Pain when breathing deep	Difficulty breathing when lying down
Asthma	Sinus Congestion,	

GASTROINTESTINAL:

Nausea	Heartburn/Indigestion	Bitter Taste in Mouth
Vomiting	Stomach Pain	Rectal Pain
Diarrhea then Constipation	Abnormal Pain/Cramps	Hemorrhoids
Diarrhea	Gas	Black Stools
Loose Stools	Belching	Bloody Stools
Constipation	Abdominal Bloating after eating	Prolapsed Organs
Chronic Laxative Use	Feeling tired after eating	
Burning Sensation after eating	Bad Breath	

SYMPTOMS - Please check any and all of the symptoms that you are currently experiencing.

GENITO-URINARY:

Impotency	Sexually Transmitted Infections	Frequent Urination
Vaginal/Penile Discharge	Kidney Stones	Other Genital issues

URINATION IS:

Normal Color	Reddish	Burning	Incontinent
Clear	Cloudy	Painful	Infrequent
Pale	Scanty	Bloody	Frequent
Dark Yellow	Odorous	Urgent	Decreasing in flow

FOR WOMEN

Are you pregnant? (circle one) YES NO UNSURE

	One (1)	Two (2)	Three (3)	Four (4)	Five (5) or more
Live Births					
Pregnancies					
Miscarriages					
Abbortions					

Age you experienced your first Period _____ Age Menopause (if applicable) _____

Date: Last Pap Smear _____ Date: Last Mammogram _____

Any History of an Abnormal Pap Smear? YES NO If so when? _____

Is your menses cycle regular YES NO Average number of days of flow _____

The flow is: (circle one) NORMAL LIGHT HEAVY

The color is (circle one) NORMAL DARK PURPLE LIGHT BROWN BROWN

Check any of the following menstruation related signs/symptoms do you experience?

Difficulty with Orgasm	Nausea	Vaginal Discharge
Pain with Intercourse	Breast Distention	Heavy discharge between cycles
Blood Clots	PMS	
Cramps	Bleeding between cycles	

FOR MEN

Do you have any unusual urinary symptoms (things that bother you)? YES NO

Check all that apply

Erectile dysfunction	Premature Ejaculation
Impotence/erectile dysfunction	Feeling of coldness/numbness in external genitalia
Difficulty with orgasm	Pain/Swelling of Testicles

other (describe)

To what extent do these conditions interfere with your daily activities (work, sleep socializing, sex exercise, etc.?

Have you sought Medical Intervention for these issues? If so when?

What treatments have you tried for these issues and how successful have they been?

MEDICAL HISTORY

Please supply the dates any of the following conditions were diagnosed

Diabetes	High Blood Pressure	Thyroid Disease	Cancer
HIV	High Cholesterol	Seizures	Hepatitis

SURGICAL HISTORY

Please provide the details of any surgeries you have had along with the date you had the procedure:

FAMILY HISTORY:

Please check any (and all) that apply and indicate how you are related to the family member with the condition

	Mother	Father	Sibling	Maternal Grandparent	Paternal Grandparent	Children
Cancer						
Hypertension						
C O P D						
Stroke						
Asthma						
Allergies						
Migraines						
Depression						
O C D						
Mental Illness						
Addiction						
Substance Abuse						
Osteoperosis						
Diabetes						
Gloucoma						

MEDICATIONS / VITAMINS & SUPPLEMENTS
List any medications you are currently taking (please include prescription medication, supplements, herbal supplements, homeopathy, Chinese medicine, and or over the counter medicines (aspirin, etc) you take on a regular basis, along with both the dosages and brands if known.

Detail and elaborate on any and all known allergies or allergic reactions you have to medications, foods, environments or chemicals.

Do you follow a specific diet? YES NO If yes, how would you describe your diet?

What do you typically eat for breakfast?

What do you typically eat for lunch?

What do you typically eat for dinner?

What do you typically eat for snacks?

What foods do you crave in between meals?

What foods do you dislike?

When you are in a "stressed out" situation what kind of food are you most apt to crave?

Salty / Greasy	Chocolate	Caffeinated	I'll eat anything
Sugar / Sweet	Nuts, seed, etc	Energy Producing	I lose my appitite

SOCIAL HISTORY

How many times a day do you?	# times/day
Drink a glass of water?	
Drink a non caffeinated soft drink with sweetener?	
Drink a non caffeinated soft drink w/o sweetener?	
Drink a caffeinated drink (tea, coffee, energy) with sweetener?	
Drink a caffeinated drink (tea, coffee, energy) w/o sweetener?	
Smoke (or ingest) cigarettes, cigars, tobacco?	
Smoke marijuana (medicinal or otherwise)	
Use Pharmacology / Medicine	

Have you ever been treated for emotional issues (check any and all that apply)

NO	I've considered Suicide	I've had neurological issues
YES	I've attempted Suicide	I've had psychological problems

Please elaborate on any neurological and or psychological issues including the dates, the types of treatments and or programs with which you were involved, the effectiveness and whether or not the issues were successfully resolved.

Have you or anyone in your family had a problem with addiction or substance abuse (check all that apply)

	Myself	Mother	Father	Siblings	Paternal Grandparent	Maternal Grandparent
Alcohol / Alcoholism						
Recreation drugs						
Prescription Drugs						
Sex / Love Addiction						
Exercise Over Exertion						
Workaholism						

In the past year, how many days have you been significantly affected by your health? _____

In the past year how many days did you feel generally poor? _____

In the past year how many trips have you had to Urgent Care or the ER? _____

In the past year, how many days did you spend in the hospital? _____

How many hours of sleep do you usually get per night during the week? _____

How you are most likely to fall asleep: (check any that most apply)

While Reading	Listening to meditation
Right after reading	Reflecting on my day
While watching TV	Worrying about my day
Right after watching TV	After grabbing a snack or something to eat
While listening to music	After drinking alcohol or smoking marijuana
Right after Listening to music	Any one of the above it varies
I toss and turn, anything that works	None of the above my head hits the pillow and I'm out

Once asleep do you sleep well and through the night? (circle one) YES NO USUALLY

Do you wake up feeling rested? (circle one) YES NO USUALLY

OCCUPATION (CHECK THE ONE THAT MOST APPLIES)

Employed	Retired, but volunteer part-time	Full Time Parent
Unemployed	Single working Parent, full time kids	Full Time Student
Retired, enjoying my freedom	Single working Parent, part time kids	

Level of enjoyment with job (check the one that most applies)

Very High	High	Moderate	Low	Very Low

Stress level with job (check the one that most applies)

Very High	High	Moderate	Low	Very Low

SPIRITUAL BELIEFS

How would you describe your spiritual beliefs (i.e. do you have a religious affiliation, belief in God or a Higher Power, do you attend services regularly, etc.)

Do you think your relationship with a higher power has anything to do with your health?

YES NO UNSURE

What practices do you engage in relative to your spiritual beliefs (i.e. prayer, meditation, community service)

Do you think your thoughts in general have anything to do with your health?

YES NO UNSURE

If you were to describe the life ethic or principle that guides you most, what would it be?

Anything else you would like to add regarding your current health, past health, goals, beliefs, etc.

SIGNIFICANT LIFE EVENTS

Besides this, describe briefly any other significant events that really impacted your life?