CENTER FOR ADVANCED MEDICINE AND CLINICAL RESEARCH
19620 W. Catawba Ave, Ste 100, Cornelius NC 28031
704-895-WELL (9355) | Fax: 877-706-1786
www.DrButtar.com

General Intake Form

Select the appropriate option and/or provide an answer to each of the items below:	
OVERVIEW OF HISTORY	
Patient's Name & Current Date	
Patient's Age & DOB	_____ Age _____ Birthdate
Patient Marital Status	☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Minor Child ☐ Engaged ☐ Domestic Partner
Patient's Ethnicity	☐ African American ☐ Asian ☐ Caucasian ☐ Hawaiian/Pacific Islander ☐ Hispanic ☐ Indian ☐ Middle Eastern ☐ Native American ☐ Other (please specify)
Patient's Gender	☐ Male ☐ Female ☐ Intersex / Hermaphrodite ☐ Transgender
Patient is from (city, state, country)	
How did you hear about our clinic?	
Have you read Dr. Buttar's book and/or watched the "Know Your Options" DVDs?	☐ Have read book ☐ Have NOT read book ☐ Have NOT watched any of the DVDs ☐ Have watched DVD: ☐ 9Steps ☐ Heavy Metals ☐ Autism ☐ Cancer ☐ Sudden Cardiac Death ☐ Trans-D Tropin
What is your current Primary Diagnoses (if any)?	
What is your current Secondary Diagnoses (if any)?	
HISTORY OF PRESENT ILLNESS	
Date symptoms began (onset of symptoms)	_____ Month _____ Year
WHAT was the initial symptoms?	
Date diagnosed	
Who made the diagnosis?	
How was diagnosis made?	☐ blood smears ☐ blood work ☐ bone biopsy ☐ bone scan ☐ core needle biopsy ☐ colonoscopy ☐ EGD ☐ intraprocedural biopsy ☐ intraoperative biopsy ☐ needle aspiration biopsy ☐ spinal tap ☐ MRI ☐ CT ☐ PET scan ☐ punch biopsy ☐ surgical excision ☐ ultrasound ☐ mammogram ☐ Other (please specify)
Most recent Pathology/Biopsy/Scan Results	
Summarize pertinent history from initial symptoms to time of diagnosis. (provide more details in Initial Intake Synopsis on the last page of this form)	
INITIAL SYMPTOMS BEFORE DIAGNOSIS	
Constitutional symptoms prior to diagnosis	☐ nausea ☐ vomiting ☐ diarrhea ☐ constipation ☐ weight change ☐ appetite ☐ change ☐ fever ☐ chills ☐ night sweats ☐ fatigue ☐ exhaustion ☐ weakness ☐ sleep issues ☐ pain ☐ swelling ☐ discomfort ☐ joint aches ☐ muscle aches ☐ Other (please specify)
Weight when initial symptoms began	_____ lbs

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Select the appropriate option and/or provide an answer to each of the items below:	
Habits when initial symptoms began (Select all appropriate options from each section	□ excellent diet □ good diet □ average diet □ poor diet □ terrible diet □ eating worse than most people □ eating healthier than most people □ eating organic foods □ eating fast food □ eating out frequently □ staying away from sugar □ no change in diet than before symptoms began □ started to diet □ stopped dieting □ optimized diet, balanced with low carb intake ---------- □ not exercising □ exercised occasionally □ exercised regularly □ increased level of exercise □ increased level of activity □ level of exercise had not changed □ continued normal level of activity without additional exercise □ decreased level of exercise □ decreased level of activity without additional exercise
Appetite when initial symptoms began	□ Excellent □ Good □ Poor □ No Appetite □ Appetite had decreased over the previous year □ Appetite was normal over the previous year □ Appetite had increased over the previous year □ Felt increased hunger associated with strong desire to eat □ Felt hunger with desire to eat □ Felt a little hunger but without much desire to eat □ Felt hunger but had minimal desire to eat □ Felt a little hunger but without desire to eat □ Felt no hunger and having no desire to eat □ Felt nauseated at the thought of food or eating
SYMPTOMS AT TIME OF DIAGNOSIS	
Constitutional symptoms at time of diagnosis (Select all appropriate options from each section)	□ no significant changes in symptoms □ significant changes in symptoms ---------- □ significant improvement of symptoms □ some improvement of symptoms □ some worsening of symptoms □ significant worsening ---------- □ increased intensity of symptoms □ decreased intensity of symptoms ---------- Symptoms at time of diagnosis included: □ nausea □ vomiting □ diarrhea □ constipation □ weight change □ appetite □ change □ fever □ chills □ night sweats □ fatigue □ exhaustion □ weakness □ sleep issues □ pain □ swelling □ discomfort □ joint aches □ muscle aches □ Other (please specify)
Weight at time of diagnosis (lbs)	_____ lbs.
Habits at time of diagnosis (Select all appropriate options from each section)	□ no changes since symptoms began ---------- □ excellent diet □ good diet □ significantly improved diet □ average but improved diet □ average diet □ poor but improved diet □ poor diet ---------- □ eating worse □ eating better □ eating fast food □ eating out frequently □ eating healthier □ eating organic foods □ eating more raw food □ juicing □ staying away from sugar ---------- □ no change in dietary habits □ started to be more conscientious about diet □ went on a specialized dietary intake protocol □ stopped specialized dietary intake protocol □ optimized diet, balanced with low carb intake ---------- □ decreased level of activity □ decreased level of activity without additional exercise □ decreased level of exercise □ continued normal level of activity without additional exercise □ did not exercise □ level of exercise did not change □ increased level of activity but without additional exercise □ started to exercise □ continued to exercise regularly □ increased level of exercise

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Select the appropriate option and/or provide an answer to each of the items below:	
Appetite at time of diagnosis	□ Excellent □ Good □ Poor □ No Appetite □ decreased since initial symptoms □ normal as it had been since initial symptoms □ increased since initial symptoms
CURRENT SYMPTOMS AS OF TODAY	
Constitutional symptoms as of today	□ significantly worsened since the time of diagnosis □ worsened since the time of diagnosis □ minimally worsened since the time of diagnosis □ unchanged since time of diagnosis □ minimally improved since initial symptoms began □ improved since initial symptoms began □ significantly improved since initial symptoms began
Symptoms as of today	□ Weight change □ Nausea □ Vomiting □ Diarrhea □ Appetite change □ Fever □ Chills □ Night sweats □ Pain □ Fatigue □ Exhaustion □ Sleep issues □ Swelling □ Discomfort □ Joint Pain □ Muscle Aches □ Other (please specify)
Current weight (lbs)	_____ lbs
Habits as of today include (Select all appropriate options from each section)	□ no changes since diagnosis □ poor diet □ poor but improved diet □ average diet □ average but improved diet □ significantly improved diet □ good diet □ excellent diet □ eating worse □ eating better □ no fast food □ eating out less frequently □ eating healthier □ stricter food regimen □ eating organic foods □ more raw food □ juicing □ staying away from sugar ---------- □ no change in dietary habits □ started to be more conscientious about diet □ went on a specialized dietary intake protocol □ stopped specialized dietary intake protocol □ optimized diet, balanced with low carb intake ---------- □ decreased level of activity □ decreased level of activity without additional exercise □ decreased level of exercise □ continued normal level of activity without additional exercise □ did not exercise □ level of exercise did not change □ increased level of activity but without additional exercise □ started to exercise □ continued to exercise regularly □ increased level of exercise
Current appetite (Select all appropriate options from each section)	□ Excellent □ Good □ Poor □ No Appetite □ unchanged since diagnosis □ decreased since diagnosis □ increased since diagnosis □ normal and unchanged since diagnosis ---------- □ Felt increased hunger associated with strong desire to eat □ Felt hunger with desire to eat □ Felt a little hunger but without much desire to eat □ Felt hunger but had minimal desire to eat □ Felt a little hunger but without desire to eat □ Felt no hunger and having no desire to eat □ Felt nauseated at the thought of food or eating

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Select the appropriate option and/or provide an answer to each of the items below:	
HISTORY OF TREATMENTS RELATED TO DIAGNOSIS	
Surgeries history related to diagnosis (Select all appropriate options from each section)	□ surgery was not recommended □ surgery was recommended □ surgery was not an option ---------- □ chose to undergo surgery □ refused to undergo surgery □ currently thinking of having the surgery
Dates of and type of surgeries history related to diagnosis	
Additional types of treatments received	
Condition after treatment regimen or surgery	
Tolerance to treatment	□ exceptionally well □ well □ reasonably □ poorly □ terribly □ terribly and could not complete the course of recommended treatment
Complications since diagnosis	
Experiencing any pain? Where?	
Medications currently being taken and purpose	
REVIEW OF SYMPTOMS	
Head/ENT - experienced in last 3 months	□ ear pain □ ear discomfort □ mouth pain □ mouth discomfort □ dental pain □ discomfort in teeth □ throat pain □ throat discomfort □ hearing loss □ ringing in the ears □ nasal discharge
Eye - experienced in last 3 months	□ blurred vision □ double vision □ eye pain □ eye discomfort □ sensitivity to light □ pain on eye movement
Respiratory - experienced in last 3 months	□ shortness of breath □ pain on deep inspiration □ tightness in chest □ coughing □ wheeze □ orthopnea □ dyspnea
Cardio - experienced in last 3 months	□ dull chest pain □ chest heaviness □ squeezing chest discomfort □ light headedness □ fluttering in chest □ swelling of legs □ fainting spells □ heart palpitations
G.I. - experienced in last 3 months	□ abdominal pain □ abdominal cramping □ abdominal distention □ nausea □ vomiting □ diarrhea □ constipation
Genito/Uri - experienced in last 3 months (Select all appropriate options from each section)	□ painful urination □ frequent urination □ urgency to urinate □ waking to urinate □ difficulty initiating urinary stream □ problem maintaining urinary stream □ hesitancy while urinating □ inability to empty bladder □ decreased urinary volume --FEMALE-- □ regular menstrual cycles □ irregular menstrual cycles □ heavy menstrual cycles □ painful menstrual cycles □ vaginal itching □ vaginal discharge □ vaginal pain --MALE-- □ penile itching □ penile discharge □ penile pain

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Select the appropriate option and/or provide an answer to each of the items below:	
Muscular/Skeletal - experienced in last 3 months	□ muscle pain □ muscle weakness □ joint pain □ decrease in range of motion
Neuro - experienced in last 3 months	□ headache □ numbness □ tingling □ right sided weakness □ left sided weakness □ poor balance / coordination □ urinary / bowel incontinence
Psych - experienced in last 3 months	□ depression □ feeling blue □ anxiety □ mood swings □ trouble sleeping □ hallucinations
Endocrine - experienced in last 3 months	□ often being cold □ often being hot □ often being thirsty □ being over tired □ losing hair
Skin – experienced in last 3 months	□ rash □ itching □ hives □ bites □ sores □ redness □ dry skin
Allergy - experienced in last 3 months	□ itchy or watery eye □ runny nose □ draining sinuses □ excessive sneezing □ itching
EXPOSURE HISTORY	
History and recent use of Tobacco (how much, how long, dates used)	
History and recent use of Alcohol (type used, how much, how long, dates used)	
History and recent use of Illicit Drug (type used, how much, how long, dates used)	
Chemical Exposure History (type, how much, how long, dates) Examples: Pesticides, Fuel, Fertilizers, Insecticides	
Metals Exposure History (type, how much, how long, dates) Examples: Lead, Aluminum, Mercury, Copper, Steel	
Vaccine History (Select all appropriate options from each section)	□ No history of childhood vaccines □ Full childhood vaccine schedule □ Participated with recommended adult vaccine schedule □ Has abstained from all recommended adult vaccines including flu shot, shingles and pneumonia Has had some recommended adult vaccines, including: □ Hepatitis A □ Hepatitis B □ Haemophilus influenza type b (Hib) □ Human papillomavirus (HPV) □ Influenza □ Meningococcal □ Measles, mumps, rubella (MMR) □ Pneumococcal □ Pneumococcal 13-valent conjugate (PCV13) □ Pneumococcal polysaccharide (PPSV23) □ Poliovirus- Inactivated □ Rotavirus □ Tetanus, diphtheria, pertussis (Td/Tdap) □ Varicella □ Zoster
How many antibiotics has patient taken in the past year?	
Any amalgams (mercury fillings) removed?	□ Yes □ No If yes, how many?
How many amalgams does patient currently have?	
Does patient have a high seafood diet?	□ Yes □ No

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Select the appropriate option and/or provide an answer to each of the items below:	
MEDICAL HISTORY	
Do you have any other medical conditions? *Example*: Hypothyroid, heart disease, lupus	
Have you had any other surgeries? *Example*: gall bladder removed, tonsils removed	
Have you undergone any other medical treatments which have not been previously noted?	
How many times have the patient been pregnant, at what age was the pregnancy, and did the pregnancy result in a live birth? (if applicable)	
Any other medical history that you feel is pertinent for the provider to know?	
Do you have any drug, food or environmental allergies or sensitivities?	
FAMILY HISTORY	
Family History - Mother	☐ Living ☐ Deceased History of: ☐ Heart issues/disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Unknown ☐ Other (please specify)
Family History - Father	☐ Living ☐ Deceased History of: ☐ Heart issues/disease ☐ Diabetes ☑ Cancer ☐ Stroke ☐ Unknown ☐ Other (please specify)
Family History - Siblings	_____ # of Siblings ☐ All Living ☐ All Deceased ☐ Some Deceased Deceased Siblings had History of: ☐ Heart issues/disease ☐ Diabetes ☐ Cancer ☐ Stroke ☐ Unknown ☐ Other (please specify)
Additional Family History (if any)	

General Intake Form

Initial Intake Synopsis

If you feel all your pertinent medical history may need further explanation or you think the provider should be aware of any additional information, please provide us with a synopsis of this information in chronological order (i.e. health timeline, diagnoses, treatments undergone, type of practitioners seen, and etc.) See "Initial Intake Synopsis Example" on next page as reference.

Date: _____ Patient Name: _____