Anita Sadaty, MD
Redefining Health

Thrive!

Thrive Initial Intake Form 1

Patient Name:_____ **Date:**_____

What are you top 3 most significant complaints/concerns?

Rate each on a scale of 0 to 10 with 0 = No symptoms and 10 = Severe symptoms

1._____ **Rating:**_____
2._____ **Rating:**_____
3._____ **Rating:**_____

When did the complaints begin?

_____

_____

_____

What was going on in your life around that time? PLEASE BE SPECIFIC

Emotionally stressful events?_____
Parents:_____
Family:_____
Work:_____
Financial:_____
Trauma/Surgery/Injury:_____
Personal Stress:_____

Dietary Stresses (circle all that apply)

CAFFEINE CARBS SUGARS ALCOHOL ERRATIC EATING UNHEALTHY FOODS

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Thrive Initial Intake Form 2

What are your complaints/concerns? (continued)

Pain and/or Inflammation (circle all that apply)

IBS MIGRAINES REFLUX GASTRITIS FIBROMYALGIA RASHES ALLERGIES
CHRONIC NECK BACK PAIN JOINT ACHES MUSCLE ACHES OTHER:_____

List all medications and supplements

1._____ 4._____ 7._____
2._____ 5._____ 8._____
3._____ 6._____ 9._____

What is the current status of your lifestyle and diet?

Exercise: time/week:_____ Type of exercise:_____
Bedtime:_____ Hours of sleep/night:_____
Gluten free? ☐ Yes ☐ No ☐ Somewhat
Dairy free? ☐ Yes ☐ No ☐ Somewhat
Soy free? ☐ Yes ☐ No ☐ Somewhat
☐ Skipping meals? ☐ Carb cravings? ☐ Binging? ☐ Weight loss?
☐ Weight gain? ☐ Alcohol (how many times a week?) _____

Stress Management: ***What are you doing to relieve stress?***

_____
_____
_____
_____
_____
_____
_____

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