



ADULT INTAKE FORM

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # home: _____ cell: _____ work: _____

Email address: _____

Age: _____ Date of Birth: _____ Gender: F/M Education: _____

Married: _____ Separated: _____ Divorced: _____ Widowed: _____ Single: _____ Partnership: _____

Live with: Spouse: _____ Partner: _____ Parents: _____ Children: _____ (list #/age _____)

Friends: _____ Alone: _____

Occupation: _____ Hours per week: _____

Employer Name/location: _____

How did you hear about this clinic? Another practitioner _____ ND directory _____

Friend/family member _____ Google search _____ Brochure/Business Card _____ Public Presentation _____

Professional Seminar _____ Other _____

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

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

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

- | | | | |
|----------------|-----------|---------------|---------------------|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anemia | Mental Illness |
| Asthma | Hay fever | Hives | Autoimmune Disease |

Any other relevant family history? _____

What is your family heritage? _____

CHILDHOOD ILLNESSES

Birth city & state: _____ Birth weight: _____

Please circle whether you had any of the following as a child:

- | | | | |
|-----------------|------------|---------------|-------------|
| Rheumatic fever | Diphtheria | Scarlet fever | Chicken pox |
| German Measles | Measles | Mumps | |

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ year _____
 _____ year _____ year _____
 _____ year _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmental or chemicals? _____

CURRENT MEDICATIONS

Do you take or use any of the following (please circle and elaborate in following section):

- | | | | |
|---------------------|---------------------|-----------------|------------------------------|
| Laxatives | Pain relievers | Antacids | Cortisone/Steroidal products |
| Antibiotics | Tranquilizers | Sleeping Pills | Thyroid Medication |
| Birth Control Pills | Hormone Replacement | Antidepressants | |

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking, along with dose:

- | | |
|----------|-----------|
| 1) _____ | 6) _____ |
| 2) _____ | 7) _____ |
| 3) _____ | 8) _____ |
| 4) _____ | 9) _____ |
| 5) _____ | 10) _____ |

GENERAL

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

TYPICAL FOOD INTAKE

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

Water intake (ounces or liters per day): _____

Alcohol intake (list types and # of drinks per day/week/month as approp.): _____

Any foods that you avoid and reason for avoiding (clarify if different than known/suspected food allergies as indicated in allergy section)? _____

FOR THE FOLLOWING, PLEASE CIRCLE:

Y=yes/condition you have now N=no/never had P= past problem

GENERAL

- Do you sleep well? Y N P
- Average 6-8 hours? Y N P
- Awake rested? Y N P
- Have a supportive relationship? Y N P
- Have a history of abuse? Y N P
- Experienced a major trauma? Y N P
- Use recreational drugs? Y N P
- Treated for drug dependence? Y N P
- Use alcoholic beverages? Y N P
- Use tobacco? Y N P
- How many packs per day? _____
- If in the past, how many years? _____
- Do you enjoy your work? Y N P
- Take vacations? Y N P
- Spend time outside? Y N P
- Eat three meals a day? Y N P
- Do you go on diets often? Y N P
- Do you eat out often? Y N P
- Do you drink coffee? Y N P
- How much per day or week? _____
- Do you drink black/green tea? Y N P
- How much per day or week? _____
- Drink soda? Y N P
- How much per day or week? _____
- Do you eat refined sugar? Y N P
- ___ rarely ___ sometimes ___ often
- Do you add salt to your food? Y N P

NEUROLOGIC

- Seizures? Y N P
- Muscle weakness? Y N P
- Loss of memory? Y N P
- Vertigo or dizziness? Y N P
- Paralysis? Y N P
- Numbness or tingling? Y N P
- Easily stressed? Y N P
- Loss of balance? Y N P

ENDOCRINE

- Hypothyroid? Y N P
- Hypoglycemia? Y N P
- Excessive thirst? Y N P
- Fatigue? Y N P
- Heat or cold intolerance? Y N P
- Hyperthyroid? Y N P
- Diabetes? Y N P

- Excessive hunger? Y N P
- Seasonal depression? Y N P
- Difficulty exercising? Y N P

IMMUNE

- Reactions to immunizations? Y N P
- Chronically swollen glands? Y N P
- Slow wound healing? Y N P
- Chronic fatigue syndrome? Y N P
- Chronic infections? Y N P
- Night sweats? Y N P

EARS

- Impaired hearing? Y N P
- Ringing in ears? Y N P
- Dizziness? Y N P
- Ear aches? Y N P

EYES

- Impaired vision? Y N P
- Cataracts? Y N P
- Glaucoma? Y N P
- Spots in vision? Y N P
- Color blindness? Y N P
- Tearing or dryness? Y N P
- Eye pain or strain? Y N P

HEAD

- Headaches? Y N P
- Migraines? Y N P
- Head injury? Y N P
- Jaw or TMJ problems? Y N P

NOSE AND SINUS

- Frequent colds? Y N P
- Stuffiness? Y N P
- Sinus problems? Y N P
- Nose bleeds? Y N P
- Hayfever? Y N P
- Loss of smell? Y N P

NECK

- Lumps in neck? Y N P
- Goiter? Y N P
- Difficulty swallowing? Y N P
- Pain or stiffness in neck? Y N P

MOUTH AND THROAT

Frequent sore throat?	Y	N	P
Copious saliva?	Y	N	P
Sore tongue or lips?	Y	N	P
Hoarseness?	Y	N	P
Jaw clicks?	Y	N	P
Teeth grinding?	Y	N	P
Gum problems?	Y	N	P
Dental cavities?	Y	N	P
# of amalgams (“silver” fillings) _____			

SKIN

Rashes?	Y	N	P
Acne/boils?	Y	N	P
Change in skin color?	Y	N	P
Lumps or bumps on skin?	Y	N	P
Eczema or hives?	Y	N	P
Itching?	Y	N	P
Perpetual hair loss?	Y	N	P

RESPIRATORY

Cough?	Y	N	P
Sputum?	Y	N	P
Asthma?	Y	N	P
Wheezing?	Y	N	P
Bronchitis?	Y	N	P
Coughing up blood?	Y	N	P
Shortness of breath?	Y	N	P
Shortness of breath when lying down?	Y	N	P
Pain in breathing?	Y	N	P
Emphysema?	Y	N	P
Tuberculosis?	Y	N	P

GASTROINTESTINAL

Trouble swallowing?	Y	N	P
Change in thirst?	Y	N	P
Change in appetite?	Y	N	P
Nausea/vomiting?	Y	N	P
Ulcer?	Y	N	P
Jaundice?	Y	N	P
Gall bladder disease?	Y	N	P
Liver disease?	Y	N	P
Hemorrhoids?	Y	N	P
Pancreatitis?	Y	N	P
Heartburn?	Y	N	P
Abdominal pain or cramps?	Y	N	P
Belching or passing gas?	Y	N	P

Constipation?	Y	N	P
Diarrhea?	Y	N	P
Bowel movements: how often? _____			
Is this a change? _____			
Black stools?	Y	N	P
Blood in stools?	Y	N	P
Undigested food in stools?	Y	N	P

MENTAL/EMOTIONAL

Treated for emotional problem?	Y	N	P
Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P
Poor concentration?	Y	N	P
Do you have mood swings?	Y	N	P
Considered suicide?	Y	N	P
Attempted suicide?	Y	N	P
Tension?	Y	N	P
Memory problems?	Y	N	P

URINARY

Increased frequency of urination?	Y	N	P
Inability to hold urine?	Y	N	P
Pain in urination?	Y	N	P
Frequency at night?	Y	N	P
Frequent UTI's?	Y	N	P
Kidney stones?	Y	N	P

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P
Arthritis?	Y	N	P
Broken bones?	Y	N	P
Weakness?	Y	N	P
Muscle spasms or cramps?	Y	N	P
Sciatica?	Y	N	P

BLOOD

Anemia?	Y	N	P
Easy bleeding or bruising?	Y	N	P
Cold hands/feet?	Y	N	P
Deep leg pain?	Y	N	P
Thrombophlebitis?	Y	N	P
Varicose veins?	Y	N	P

CARDIOVASCULAR

High Blood Pressure?	Y	N	P
Heart Palpitations?	Y	N	P
Angina?	Y	N	P
Rheumatic fever?	Y	N	P

Murmurs? Y N P
 Swelling in ankles? Y N P
 Heart Disease? Y N P
 Heart Attack? Y N P

FEMALE REPRODUCTIVE

Age of first menses: _____
 Age of last menses (if menopausal): _____
 Are your cycles regular? Y N P
 Cycle length (e.g., 28-30 days): _____ days
 Duration of menses: _____ days
 Painful menses? Y N P
 Heavy or excessive flow? Y N P
 PMS? Y N P
 PMS symptoms: _____

Bleeding between cycles? Y N P
 Clotting? Y N P
 Endometriosis? Y N P
 Ovarian cysts? Y N P
 Vaginal odor? Y N P
 Vaginal discharge? Y N P

Date of last pap smear: _____
 Abnormal PAP? Y N P
 Cervical dysplasia? Y N P
 Are you sexually active? Y N P

Sexual orientation: _____
 Birth control? Type: _____
 If hormonal birth control, how long? _____

Pain during intercourse? Y N P
 Gonorrhea? Y N P
 Herpes? Y N P
 Chlamydia? Y N P
 Genital warts? Y N P
 Syphilis? Y N P
 Difficulty conceiving? Y N P

Number of pregnancies: _____
 Number of live births: _____
 Number of miscarriages: _____
 Number of abortions: _____

Do you do self breast exams? Y N P
 Breast pain/tenderness? Y N P
 Breast lumps? Y N P
 Nipple discharge? Y N P
 Menopausal symptoms? Y N P

List (include even if in past): _____

MALE REPRODUCTIVE

Are you sexually active? Y N P
 Sexual orientation: _____
 Birth control? Type: _____
 Discharge or sores? Y N P
 Chlamydia? Y N P
 Gonorrhea? Y N P
 Genital warts? Y N P
 Herpes? Y N P
 Syphilis? Y N P
 Hernias? Y N P
 Testicular masses? Y N P
 Testicular pain? Y N P
 Prostate disease? Y N P
 Impotence? Y N P
 Premature ejaculation? Y N P

CONTEXT OF CARE REVIEW (Optional)

*****This section of the intake form is optional. Please fill out if you have the time to complete and are inclined to do so. It can be very helpful to me as a practitioner in understanding your goals and desires in achieving optimal health and wellness*****

Successful health care and preventive medicine are best accomplished when the doctor has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0 (0%) 1 2 3 4 5 6 7 8 9 10 (100%)

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.

