ADULT INTAKE FORM

Name: ____ Date: ____________________

Address: ____

City: ___________________________ State: ___________ Zip: _________________________

Phone # cell: _________________ home: ___________________ work: ____________________

Email address: ____

Age: ____ Date of Birth: __________ Gender: F/M/Other _______ 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 Yelp 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 and main issue(s)? ____

____

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

____

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, please specify? ____

____

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, EEGs, EKGs, etc. have you had?

______________________ year ________ ______________________ year ________

______________________ year ________ ______________________ year ________

______________________ year ________ ______________________ year ________

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs (prescription or OTC), herbs, supplements? ______________________________

____

Any foods? ____

____

Any environmentals or chemicals? ____

____

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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	

Approximate number of courses of antibiotics taken in past year ________; in past 5 years ___________

Please list any prescription medications, over the counter medications, herbs, vitamins or other supplements you are currently 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 hrs/day? ______ Read: Y / N If so, how many hrs/day? ________

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 (oz or liters/day): ______________

Alcohol intake (types and # of drinks per day/wk/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)?____

____

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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
- Avg. 7-9 hours of sleep per night? 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
- Any mold or musty odors in residence or work environment? 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
- Tension? Y N P
- Mood swings? Y N P
- Poor concentration? Y N P
- Memory problems? Y N P
- Considered suicide? Y N P
- Attempted suicide? Y N P

URINARY

- Inability to hold urine? Y N P
- Pain with urination? Y N P
- Increased frequency of urination? Y N P
- Urinary 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

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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 (e.g., 4-5 d): ________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

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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%)

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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.