

## 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:\_\_\_ Friends:\_\_\_ Alone:\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_

Employer Name and Address: \_\_\_\_\_

How did you hear about this clinic? \_\_\_\_\_

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

Emergency contact: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

### CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician 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?

## CONTEXT OF CARE REVIEW

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?

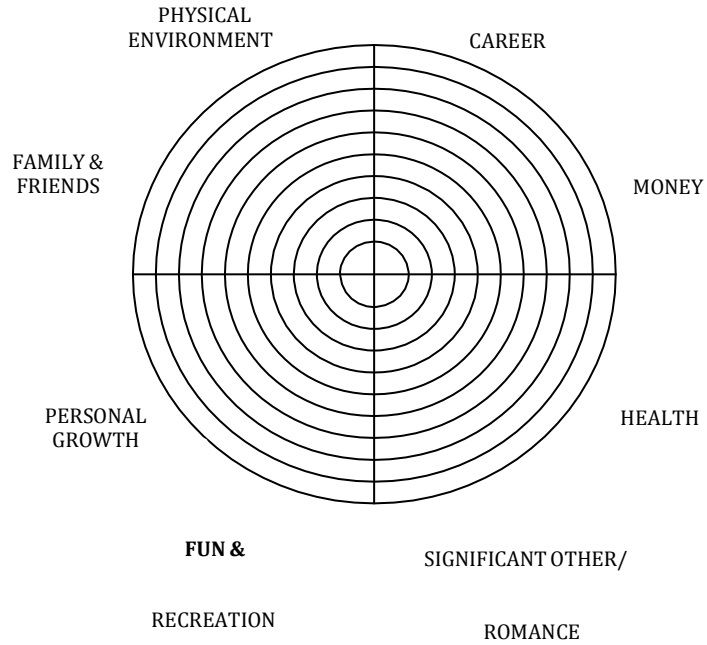
What do you love to do?

### 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.



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
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history? \_\_\_\_\_

What is your family heritage? \_\_\_\_\_

### CHILDHOOD ILLNESSES

Birth city & state: \_\_\_\_\_ Birth time: \_\_\_\_\_ Birth weight: \_\_\_\_\_

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

Rheumatic fever	Diphtheria	Scarlet fever	Chicken
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):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid
Birth Control Pills	Hormone Replacement		

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

1) \_\_\_\_\_ 5) \_\_\_\_\_  
2) \_\_\_\_\_ 6) \_\_\_\_\_  
3) \_\_\_\_\_ 7) \_\_\_\_\_  
4) \_\_\_\_\_ 8) \_\_\_\_\_

### 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: \_\_\_\_\_

**FOR THE FOLLOWING, PLEASE CIRCLE:**

**Y**=yes/condition you have now **N**=no/never had **P**= problem in the past **S**=sometimes a problem

<b>GENERAL</b>					Dizziness?	Y	N	P	S
Do you sleep well?	Y	N	P	S	Ear aches?	Y	N	P	S
Average 6-8 hours?	Y	N	P	S	<b>EYES</b>				
Awake rested?	Y	N	P	S	Impaired vision?	Y	N	P	S
Have a supportive relationship?	Y	N	P	S	Cataracts?	Y	N	P	S
Have a history of abuse?	Y	N	P	S	Glaucoma?	Y	N	P	S
Experienced a major trauma?	Y	N	P	S	Spots in vision?	Y	N	P	S
Use recreational drugs?	Y	N	P	S	Color blindness?	Y	N	P	S
Treated for drug dependence?	Y	N	P	S	Tearing or dryness?	Y	N	P	S
Use alcoholic beverages	Y	N	P	S	Eye pain or strain?	Y	N	P	S
Use tobacco?	Y	N	P	S	<b>HEAD</b>				
If yes ,in the past, how many years					Headaches?	Y	N	P	S
How many packs per day?					Migraines?	Y	N	P	S
Do you enjoy your work?	Y	N	P	S	Head injury?	Y	N	P	S
Take vacations?	Y	N	P	S	Jaw or TMJ problems?	Y	N	P	S
Spend time outside?	Y	N	P	S	<b>NOSE AND SINUS</b>				
Eat three meals a day?	Y	N	P	S	Frequent colds?	Y	N	P	S
Do you go on diets often?	Y	N	P	S	Stiffness?	Y	N	P	S
Do you eat out often?	Y	N	P	S	Sinus problems?	Y	N	P	S
Do you drink coffee?	Y	N	P	S	Nose bleeds?	Y	N	P	S
Drink black/green tea?	Y	N	P	S	Hayfever?	Y	N	P	S
Drink soda?	Y	N	P	S	Loss of smell?	Y	N	P	S
Do you eat refined sugar?	Y	N	P	S	<b>NECK</b>				
Do you add salt to your food?	Y	N	P	S	Lumps in neck?	Y	N	P	S
<b>ENDOCRINE</b>					Goiter?	Y	N	P	S
Hypothyroid?	Y	N	P	S	Difficulty swallowing?	Y	N	P	S
Hypoglycemia?	Y	N	P	S	<b>MOUTH AND THROAT</b>				
Excessive thirst?	Y	N	P	S	Frequent sore throat?	Y	N	P	S
Fatigue?	Y	N	P	S	Copious saliva?	Y	N	P	S
Heat or cold intolerance?	Y	N	P	S	Sore tongue or lips?	Y	N	P	S
Hyperthyroid?	Y	N	P	S	Hoarseness?	Y	N	P	S
Diabetes?	Y	N	P	S	Jaw clicks?	Y	N	P	S
Excessive hunger?	Y	N	P	S	Teeth grinding?	Y	N	P	S
Seasonal depression?	Y	N	P	S	Gum problems?	Y	N	P	S
Difficulty exercising?	Y	N	P	S	Dental cavities?	Y	N	P	S
<b>IMMUNE</b>					<b>SKIN</b>				
Reactions to immunizations?	Y	N	P	S	Rashes?	Y	N	P	S
Chronically swollen glands?	Y	N	P	S	Acne/boils?	Y	N	P	S
Slow wound healing?	Y	N	P	S	Change in skin color?	Y	N	P	S
Chronic fatigue syndrome?	Y	N	P	S	Lumps or bumps on skin?	Y	N	P	S
Chronic infections?	Y	N	P	S	Eczema or hives?	Y	N	P	S
Night sweats?	Y	N	P	S	Itching?	Y	N	P	S
<b>NEUROLOGIC</b>					Perpetual hair loss?	Y	N	P	S
Seizures?	Y	N	P	S	<b>RESPIRATORY</b>				
Muscle weakness?	Y	N	P	S	Cough?	Y	N	P	S
Loss of memory?	Y	N	P	S	Sputum?	Y	N	P	S
Vertigo or dizziness?	Y	N	P	S	Asthma?	Y	N	P	S
Paralysis?	Y	N	P	S	Wheezing?	Y	N	P	S
Numbness or tingling?	Y	N	P	S	Bronchitis?	Y	N	P	S
Easily stressed?	Y	N	P	S	Coughing up blood?	Y	N	P	S
Loss of balance?	Y	N	P	S	Shortness of breath?	Y	N	P	S
<b>EARS</b>					Shortness of breath when lying down?	Y	N	P	S
Impaired hearing?	Y	N	P	S	Pain in breathing?	Y	N	P	S
Ringin g in ears?	Y	N	P	S	Emphysema?	Y	N	P	S

Tuberculosis?	Y	N	P	S
<b>GASTROINTESTINAL</b>				
Trouble swallowing?	Y	N	P	S
Change in thirst?	Y	N	P	S
Change in appetite?	Y	N	P	S
Nausea/vomiting?	Y	N	P	S
Ulcer?	Y	N	P	S
Jaundice?	Y	N	P	S
Gall bladder disease?	Y	N	P	S
Liver disease?	Y	N	P	S
Hemorrhoids?	Y	N	P	S
Pancreatitis?	Y	N	P	S
Heartburn?	Y	N	P	S
Abdominal pain or cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S
Bowel movements: how often?	Y	N	P	S
Is this a change?	Y	N	P	S
Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S
<b>MENTAL/EMOTIONAL</b>				
Treated for emotional problem?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Do you have mood swings?	Y	N	P	S
Considered suicide?	Y	N	P	S
Attempted suicide?	Y	N	P	S
Tension?	Y	N	P	S
Memory problems?	Y	N	P	S
<b>URINARY</b>				
Increased frequency of urination?	Y	N	P	S
Inability to hold urine?	Y	N	P	S
Pain in urination?	Y	N	P	S
Frequency at night?	Y	N	P	S
Frequent UTI's?	Y	N	P	S
Kidney stones?	Y	N	P	S
<b>MUSCULOSKELETAL</b>				
Joint pain or stiffness?	Y	N	P	S
Arthritis?	Y	N	P	S
Broken bones?	Y	N	P	S
Weakness?	Y	N	P	S
Muscle spasms or cramps?	Y	N	P	S
Sciatica?	Y	N	P	S
<b>BLOOD</b>				
Anemia?	Y	N	P	S
Easy bleeding or bruising?	Y	N	P	S
Cold hands/feet?	Y	N	P	S
Deep leg pain?	Y	N	P	S
Thrombophlebitis?	Y	N	P	S
Varicose veins?	Y	N	P	S

**FEMALE REPRODUCTIVE**

Age of first menses: \_\_\_\_\_  
 Age of last menses (if menopausal): \_\_\_\_\_  
 Length of cycle: \_\_\_\_\_

Duration of menses:				
Are your cycles regular?	Y	N	P	S
Painful menses?	Y	N	P	S
Heavy or excessive flow?	Y	N	P	S
PMS?	Y	N	P	S
Symptoms?				
Bleeding between cycles?	Y	N	P	S
Clotting?	Y	N	P	S
Endometriosis?	Y	N	P	S
Ovarian cysts?	Y	N	P	S
Vaginal odor?	Y	N	P	S
Vaginal discharge?	Y	N	P	S
Date of last pap smear:				
Abnormal PAP?	Y	N	P	S
Cervical dysplasia?	Y	N	P	S
Are you sexually active?	Y	N	P	S
Sexual orientation:				
Birth control? Type:				
Pain during intercourse?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Herpes?	Y	N	P	S
Chlamydia?	Y	N	P	S
Genital warts?	Y	N	P	S
Syphilis?	Y	N	P	S
Difficulty conceiving?	Y	N	P	S
Number of pregnancies:				
Number of live births:				
Number of miscarriages:				
Number of abortions:				
Do you do self breast exams?	Y	N	P	S
Breast pain/tenderness?	Y	N	P	S
Breast lumps?	Y	N	P	S
Nipple discharge?	Y	N	P	S
Menopausal symptoms?	Y	N	P	S
<b>MALE REPRODUCTIVE</b>				
Are you sexually active?	Y	N	P	S
Sexual orientation:				
Birth control? Type:				
Discharge or sores?	Y	N	P	S
Chlamydia?	Y	N	P	S
Gonorrhea?	Y	N	P	S
Genital warts?	Y	N	P	S
Herpes?	Y	N	P	S
Syphilis?	Y	N	P	S
Hernias?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S