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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?

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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?

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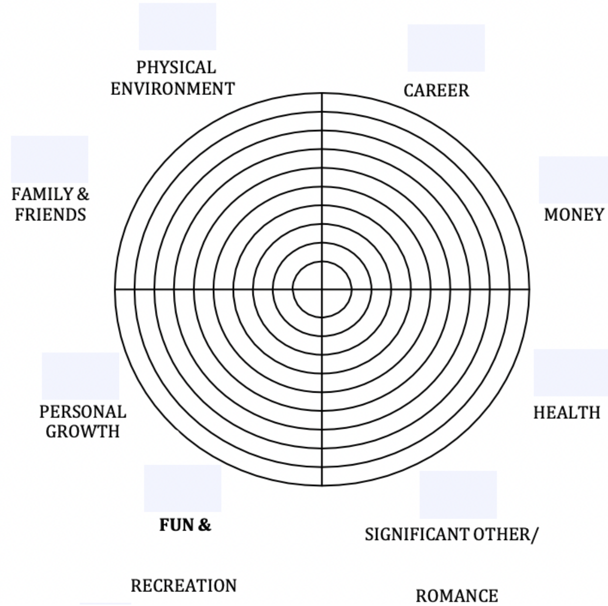
WHEEL OF BALANCE

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 not, 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? ____

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FAMILY HISTORY

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

Cancer	Kidney disease Epilepsy	Anemia
Diabetes	Arthritis	Mental Illness
Heart	Glaucoma	Asthma
Disease	Tuberculosis	Hay fever
High Blood	Stroke	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	Chicken	Measles
Diphtheria Scarlet fever	German 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 environmentals or chemicals? ______________________________

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CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

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

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: ______________________________

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FOR THE FOLLOWING, PLEASE CIRCLE:

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

GENERAL

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

ENDOCRINE

Hypothyroid?	Y N P S
Hypoglycemia?	Y N P S
Excessive thirst?	Y N P S
Fatigue?	Y N P S
Heat or cold intolerance?	Y N P S
Hyperthyroid?	Y N P S
Diabetes?	Y N P S
Excessive hunger?	Y N P S
Seasonal depression?	Y N P S
Difficulty exercising?	Y N P S

IMMUNE

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

NEUROLOGIC

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

EARS

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

EYES

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

HEAD

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

NOSE AND SINUS

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

NECK

Lumps in neck?	Y N P S
Goiter?	Y N P S
Difficulty swallowing?	Y N P S

MOUTH AND THROAT

Frequent sore throat?	Y N P S
Copious saliva?	Y N P S
Sore tongue or lips?	Y N P S
Hoarseness?	Y N P S
Jaw clicks?	Y N P S
Teeth grinding?	Y N P S
Gum problems?	Y N P S
Dental cavities?	Y N P S

SKIN

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

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RESPIRATORY

Cough? Y N P S
Sputum? Y N P S
Asthma? Y N P S
Wheezing? Y N P S

Tuberculosis? Y N P S

GASTROINTESTINAL

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

MENTAL/EMOTIONAL

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

URINARY

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

MUSCULOSKELETAL

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

BLOOD

Anemia? Y N P S
Easy bleeding or bruising? Y N P S
Cold hands/feet? Y N P S

Bronchitis? Y N P S
Coughing up blood? Y N P S
Shortness of breath? Y N P S
Shortness of breath when lying down? Y N P S
Pain in breathing? Y N P S Emphysema? 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

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MALE REPRODUCTIVE

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