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ADULT INTAKE FORM

Name: ______________________________ Date: ____________________

Date of birth: ____________________ Age: ____________ Gender: ____________

Address: ____

City: ______________________________ State:__________ Zip: ____________

E-mail: ____

Phone: (Home): __________________ (Cell/Work): _________________________

May we leave phone messages relating to your visits? Yes No

Emergency Contact Name: ____________________ Relationship: _______________

Phone: ______________________ Address: ______________________________

How did you hear about our clinic? _____________________________________

If Internet: Google: _____ AHG: ____ AANP: ____ OANP: ____ Other website: _______________

Occupation: _________________________ Hours per week: __________________

Married: ____ Separated: ____ Divorced: ____ Widowed: ____ Single: ____ Partnership: __________

Live with: Spouse: ____ Partner: ____ Parents: ____ Children: ____ Friends: ____ Alone: _________

Family Physician: ____________________ Phone: ___________________________

What are your main health concerns, in order of importance to *you*:

1. ____

2. ____

3. ____

4. ____

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CONTEXT OF CARE

Successful health care and preventive medicine are only possible when the physician understands the patient physically, mentally and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly improve our ability to help with your health needs. Feel free to use the back of this form if needed.

Why did you choose to come to this office?

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 us personally as your health care providers?

What is your present level of commitment to address any underlying causes of your signs and symptoms that may relate to your lifestyle? Rate from 1 to 10, 10 being 100% committed.

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?

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CONTEXT OF CARE, continued

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

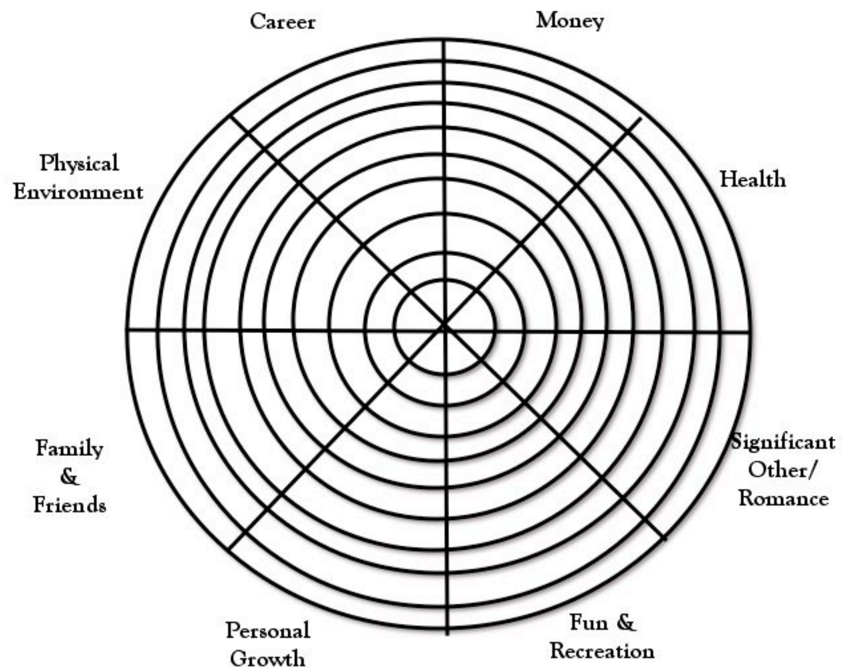
What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

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 HEALTH

Wellness is a balance of many factors. Using the Wheel of Health, shade in your level of satisfaction for each category, starting in the center. For instance, if you are 60% satisfied in the Physical Environment section, shade in 6 levels.



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MEDICAL HISTORY

Date of last physical exam: ___________ Current Height: _____________ Weight: _____________

Maximum Weight: ___________ When? _________ Energy level (1-10, 10 highest): ___________

Are you hypersensitive or allergic to:

Any drugs? _______________________________________ Foods? ___________________________________

Environment/Chemicals? ____

How would you describe your general health?

Excellent Good Fair Poor

Other treatments or health care? (e.g. physiotherapy, massage, chiropractic, etc. – please list names, and continue on back if necessary):

____

____

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations; along with approximate dates:

____

____

____

____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Yes No

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

Which medications, either by prescription or over the counter, are you taking or have you taken in the past 6 months?

- ☐ Laxatives
- ☐ Appetite Suppressants
- ☐ Antacids
- ☐ Antibiotics
- ☐ Birth control pills
- ☐ Hormone replacement
- ☐ Cortisone/Prednisone
- ☐ Thyroid medication
- ☐ Antidepressants
- ☐ Sleeping medications
- ☐ Anticonvulsants
- ☐ Sedatives
- ☐ Blood pressure meds
- ☐ Diuretics
- ☐ Cholesterol-lowering medication
- ☐ Chemotherapy
- ☐ Pain Relievers
- ☐ H2 Blockers/Ulcer medication

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MEDICAL HISTORY, continued

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known. *Note: Please bring each of these with you to your first office visit.*

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________

(continue on back if necessary)

Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

☐ Anemia	☐ Cancer	☐ Heart Disease	☐ Mental Illness	☐ Alzheimer's
☐ Arthritis	☐ Diabetes	☐ Hypertension	☐ Multiple Sclerosis	☐ Stroke
☐ Asthma	☐ Epilepsy	☐ Kidney Disease	☐ Parkinson's	☐ Other (list below)

Please list other significant family medical history not listed above:

____
____
____

REVIEW OF SYSTEMS

For the following conditions/symptoms, please circle:
Y = Currently have condition N = Never P = Significant problem in past S = Sometimes have condition

<u>General</u>

Do you sleep well?	Y	N	P	S
Average 6-8 hours?	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
Drug/alcohol dependence?	Y	N	P	S
Use alcoholic beverages?	Y	N	P	S
Use tobacco?	Y	N	P	S
Do you enjoy your work?	Y	N	P	S
Take vacations?	Y	N	P	S
Spend time outside?	Y	N	P	S
Exercise daily?	Y	N	P	S
Eat three meals a day?	Y	N	P	S

<u>Neurologic</u>

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

Neurologic, cont.

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

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? Excessive hunger?	Y	N	P	S
Seasonal depression?	Y	N	P	S
Difficulty losing weight?	Y	N	P	S

Immune

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

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

Ears

Impaired hearing?	Y	N	P	S
Ringing in ears?	Y	N	P	S
Dizziness?	Y	N	P	S
Earaches?	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

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

Mouth and throat

Frequent sore throat?	Y	N	P	S
Copious saliva?	Y	N	P	S

Mouth and throat Cont.

Sore tongue or lips?	Y	N	P	S
Hoarseness?	Y	N	P	S
Teeth grinding?	Y	N	P	S
Gum problems?	Y	N	P	S
Dental cavities?	Y	N	P	S

Neck

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

Skin

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

Respiratory

Cough?	Y	N	P	S
Sputum?	Y	N	P	S
Asthma?	Y	N	P	S
Wheezing?	Y	N	P	S
Bronchitis?	Y	N	P	S
Coughing up blood?	Y	N	P	S
Shortness of breath?	Y	N	P	S
Painful breathing?	Y	N	P	S
Emphysema?	Y	N	P	S
Tuberculosis?	Y	N	P	S
Shortness of breath lying down?	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, cramps?	Y	N	P	S
Belching or passing gas?	Y	N	P	S
Constipation?	Y	N	P	S

Bowel movements: how often? ____________

Is this a change? ________________

Black stools?	Y	N	P	S
Blood in stools?	Y	N	P	S

Mental Emotional

Treated for emotional problems?	Y	N	P	S
Depression?	Y	N	P	S
Anxiety or nervousness?	Y	N	P	S
Poor concentration?	Y	N	P	S
Mood swings?	Y	N	P	S
Considered 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 urinary infections?	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
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: ________ days

Duration of menses: ____________days

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

Female Reproductive, cont.

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
Are you sexually active?	Y	N	P	S

If yes, with men, women or both?

Birth control? Y N P S

Type(s): _________________

STD prevention? Y N P S

Type(s): _________________

Pain during intercourse?	Y	N	P	S
Sexually transmitted infections?	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

Male Reproductive

Are you sexually active? Y N P S

If yes, with men, women or both?

Birth control? Y N P S

Type(s): _________________

STD prevention? Y N P S

Type(s): _________________

Discharge or sores?	Y	N	P	S
Sexually transmitted infections?	Y	N	P	S
Testicular masses?	Y	N	P	S
Testicular pain?	Y	N	P	S
Do you do self testicular exams?	Y	N	P	S
Prostate disease?	Y	N	P	S
Erectile dysfunction?	Y	N	P	S
Premature ejaculation?	Y	N	P	S