



Adult Intake Form

Last Name: _____ **First:** _____ **Age:** _____
DOB: _____
Date: _____

List your medical problems:

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

Last time you had blood work done and with what doctor: _____

FAMILY HISTORY

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer (type)	_____	_____	_____	_____	_____	_____
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-immune disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries and Hospitalizations—including date occurred:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Please Note When and Why You Had Each of The Following:

X-rays: _____
 MRI/Cat Scans: _____
 Ultrasounds: _____
 Accidents: _____

Please List All Sensitivities/Allergies/Reactions

Drugs: _____
Foods: _____
Environment: _____

Did you have the following Disease (D), Get Immunized for it (I), or Neither (N):

Measles: D I N Diptheria: D I N
Mumps: D I N Tetanus: D I N
Rubella: D I N Whooping Cough: D I N
Chickenpox: D I N Hemophilus (Hib): D I N
German Measles: D I N Hepatitis B: D I N

Any vaccination reactions: _____

List Yes, No, or Past regarding use of the following:

Antacids: Y P Steroids: Y N P
Smoking: Y P Packs per day if Yes/Past: _____
Analgesics: Y P Laxatives: Y N P
Coffee: Y P Cups per day if Yes/Past: _____
Soda Pop: Y P Ounces per day if Yes/Past: _____
Alcohol: Y P How often and how much if Yes/Past: _____
Any alcohol addiction: Y P Any alcohol treatment: Y P
Recreational drugs: Y P Any drugs addiction: Y P
Any drug treatment: Y P

List all Prescription Medicines, Supplements, & Herbs You Take: INCLUDE DOSAGE

Exercise:

How often?: _____ What type?(s): _____
For How long: _____

Hobbies: _____

Sleep:

How long per night: _____ If you wake up frequently, what is the reason?:

Nightmares: Y P Wake refreshed: Y P Must Nap during the day: Y P
Sleep walk: Y P Grind Teeth: Y P Snore: Y P

Typical Days Diet:

How much water do you drink? _____
Breakfast: _____
Lunch: _____
Dinner: _____
Snack: _____

Toxin Exposure:

Did you grow up near any refinery, or polluted area, or in home with leaded paint? If so, what sort of pollution were you exposed to?: _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials?: _____

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets, or did other refurbishing?: _____

Are you particularly sensitive to perfumes, gasoline, or other vapors?: _____

Do you use pesticides, herbicides, other chemicals around your home? _____

Social Life:

Enjoy job?: Y P Active Spiritual practice: Y P

Quality of most significant relationship? _____

History of sexual, mental/emotional, physical abuse?: Y P

If so, at what age and by whom?: _____

What is your greatest health concern? _____

How does it limit you the most? _____

How committed are you towards making valuable changes: Little Moderately Very

REVIEW OF SYSTEMS

Present Weight: _____ Weight one year ago: _____

Height: _____ Maximum weight and when: _____

Minimum Weight as adult and when: _____

Ideal Weight: _____

Regarding the Next Section: Please Circle Y if you have the problem now, P if you had the problem in the PAST.

If two symptoms are listed, circle the one (s) you have.

Good Energy: Y P

Fatigue: Y P

If you have fatigue, when in morning, afternoon, evening is it the worst?: _____

If you have fatigue, can you do what you need to during the day?: Y N

SKIN

Rash: Y P

Lump: Y P

Psoriasis/eczema: Y P

Hives: Y P

Itchy: Y P

Cancer: Y P

HEAD

Headache: Y P

Head Injury: Y P

EYES

Blurry vision: Y P

Glaucoma: Y P

Migraine: Y P

Styes: Y P

Double vision: Y P

Cataracts: Y P

Itchy: Y P

EARS

Decreased Hearing Y P
 Ear Pain: Y P
 Drainage: Y P
 Dizziness: Y P

NOSE

Frequent colds: Y P
 Nosebleeds: Y P
 Congestion: Y P
 Post nasal drip: Y P
 Polyps: Y P
 Seasonal allergies: Y P

NECK

Stiffness: Y P
 Swollen glands: Y P
 Full movement: Y P
 Tension: Y P

BREAST

Lumps: Y P
 Nipple discharge: Y P
 Self examination : Y P

CARDIOVASCULAR

High blood pressure: Y P
 Rheumatic Fever: Y P
 Low blood pressure: Y P
 Murmurs: Y P
 Arrhythmias: Y P
 Palpitations: Y P
 Edema: Y P
 Chest pain: Y P
 Leg/feet swelling: Y P

ENDOCRINE

Change in Appetite: Y P
 Diabetes: Y P
 Heat/Cold intolerance Y P
 Thyroid problem Y P
 Difficulty maintaining weight: Y P

URINARY

Discharge/blood: Y P
 Incontinence: Y P
 Pain with urination: Y P
 Frequent infections: Y P
 Kidney stones: Y P
 Urgency: Y P

Discharge: Y P
 Dark under eyelid: Y P

MOUTH/THROAT

Canker sores: Y P
 Cold sores: Y P
 Sore throat: Y P
 Gum disease: Y P
 Dentures: Y P
 Cavities: Y P
 Loss of taste: Y P
 Hoarseness: Y P

RESPIRATORY

Cough: Y P
 Shortness of breath with exertion: Y P
 Tuberculosis: Y P
 Bronchitis: Y P
 Pneumonia: Y P
 Asthma: Y P
 Wheezing: Y P
 Painful breathing: Y P
 Shortness of breath lying down: Y P

GASTROINTESTINAL

Heartburn: Y P
 Bowel movement frequency: _____
 Indigestion: Y P
 Recent change in BM: Y P
 Bloating: Y P
 Diarrhea or constipation: Y P
 Nausea: Y P
 Hemorrhoids: Y P
 Gall bladder disease: Y P
 Liver disease: Y P
 Ulcer: Y P
 Vomiting: Y P
 Pancreatitis: Y P

HEMATOLOGIC

Anemia: Y P
 Easy bruising/bleeding Y P
 Transfusions: Y P

MALE

Testicular pain/swelling: Y P
Hernia: Y P
Discharge: Y P
Impotency: Y P

Sexually active: Y P
Sexually transmitted disease: Y P
Prostate disease/symptoms: Y P
Sexual orientation: Hetero Homo Bi

FEMALE

Age periods began: _____
How long periods last: _____
Periods:
Heavy Bleeding: Y P
Cramping: Y P
Pain: Y P
PMS: Y P
Food Cravings: Y P
Last Pap Smear: _____
Diagnosis: _____
Any abnormal paps: Y P
When was abnormal: Y P
Any Birth Control (please list types and ages used): _____
Sexually Transmitted Diseases: Y P
Mammography: Y P
Dexa Scan: Y P If Yes, what were the results: _____
Use of Hormones: Y P

How often periods occur: _____
Menopausal since what age: _____
Times Pregnant: _____
How many births: _____
Miscarriages: _____
Abortions: _____
Sexual Active: Y N P
Healthy Libido: Y N P
Pain with Intercourse: Y P
Dry Vagina: Y P
Vaginitis: Y P

MUSKULOSKELETAL

Weakness: Y P
Arthritis: Y P
Stiffness: Y P
Leg cramps: Y P
Tremors: Y P
Pain: Y P

NERVOUS

Paralysis: Y P
Tingling/numbness: Y P
Seizures: Y P
Sciatica: Y P
Carpal tunnel syndrome: Y P
Fainting: Y P

MENTAL/EMOTIONAL

Sadness: Y P
Hopelessness: Y P
Suicidal: Y P
Anxiety : Y P

Anger/irritability: Y P
High-strung/tense: Y P
Fear/Panic: Y P