Adult Intake Form

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

Describe the Reason(s) for Your Visit: _____
_____

What is Your Greatest Health Concern?_____
How Does It Limit You the Most? _____
How Committed Are You Towards Making Valuable Changes: Little Moderately Very

MEDICAL HISTORY:
List Your Medical Diagnoses:
1) _____
2) _____
3) _____
4) _____
5) _____
Last Time You Had Blood Work Done and With What Doctor: _____

List All Surgeries, Hospitalizations & Traumas — Including Date Occurred:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

When and What Were the Results of the Following:
Electrocardiogram (ECG): _____
Echocardiogram: _____
Colonoscopy: _____
Mammogram: _____

Please List All Sensitivities/Allergies/Reactions:
Drugs: _____
Foods: _____
Environment: _____

Please Circle ALL that Apply: LEAVE BLANK *if you've never had the disease.*
Circle D *if you had the* ***DISEASE. Circle I*** *if you were* ***IMMUNIZED*** *with vaccinations.*

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

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Influenza: D I Pneumonia: D I
Any Vaccination Reactions:_____

SUBSTANCES:
***Please Circle ALL that Apply**: LEAVE BLANK if you've never had the symptom.*
Circle C** if you **CURRENTLY** use the following substances. **Circle P** if you have in the **PAST.

Antacids:	C P	E-cigarette:	C P
Steroids:	C P	Marijuana/CBD:	C P
Analgesics:	C P	Recreational drugs:	C P
Laxatives:	C P	Drug addiction:	C P
Coffee:	C P	Recreational drug treatment:	C P
Cups per day:	_____	Type of drugs:	
Soda:	C P	_____	
Ounces per day:	_____	Alcohol:	C P
Energy ddrinks:	C P	How much per day:	_____
Tobacco:	C P	Alcohol addiction:	C P
Packs per day:	_____	Alcohol treatment:	C P

List all CURRENT CURRENT Prescription Medicines, Supplements, & Herbs You Take:

Name of Supplement/Medication	Dosage	Reason(s) for Taking Supplement/Medication	Does It Help? (Yes or No)

HEALTH HABITS
EXERCISE:
How often?:_____ What type(s)?:_____
How long?:_____

HOBBIES:_____

SLEEP:
How long per night (hours): _____ Work: Day Shift or Night Shift
If you wake up frequently, what is the reason: _____

Wake unrefreshed:	C P	Snore loudly:	C P
Sleep apnea:	C P	Tired/Fatigued/Sleepy	
Have you had a sleep study:	C P	during the day:	C P
Stop breathing during sleep:	C P	Grind teeth:	C P

MEALS:
Meals per day: _____
What do you eat for:
Breakfast: _____
Lunch: _____

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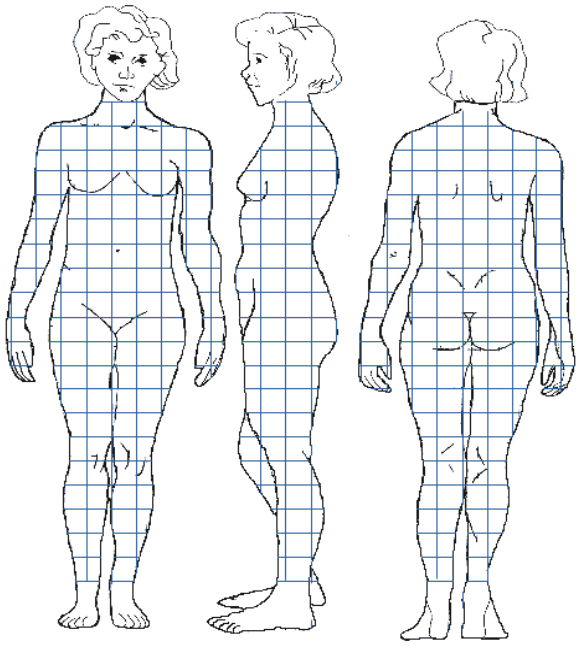
Dinner: _____
Snacks: _____
How much water do you drink per day?: _____
Other beverages?: _____

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 N Active spiritual practice: Y N
Satisfaction with where you are in life: _____
_____
Stress Level: High Medium Low
Quality of most Significant Relationship: _____
Who do you live with by relationship: _____
History of sexual, mental/emotional/physical abuse?: Y N
If so, at what age and by whom?: _____

PAIN CHART
Please Mark (X) the Location of Your Pain Including Any Radiation.



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FAMILY HISTORY:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age (Living)	_____	_____	_____	_____	_____	_____
Age (Deceased)	_____	_____	_____	_____	_____	_____
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
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
Alzheimer's	Y N	Y N	Y N	Y N	Y N	Y N
Tuberculoses (TB)	Y N	Y N	Y N	Y N	Y N	Y N

REVIEW OF SYSTEMS

Weight one year ago: _____ Recent weight gain, when & why: _____

Ideal weight: _____ Recent weight loss, when & why: _____

***Please Circle ALL Symptoms that Apply**: LEAVE BLANK if you've never had the symptom.*
Circle C** if you have the problem **CURRENT**. **Circle P** if you had the problem in the **PAST.
Circle Y** for **YES. Circle N** for **NO.

Good energy: Y N
Fatigue: Y N
If fatigued, when is it the worst? Morning Afternoon Evening
If fatigued, can you do what you need to during the day?: Y N

SKIN

Rash:	C	P
Hives:	C	P
Lump:	C	P
Itchy:	C	P
Psoriasis/Eczema:	C	P
Skin cancer:	C	P

HEAD

Headache:	C	P
Head injury:	C	P
Migraine:	C	P
TMJ	C	P

NECK

Stiffness:	C	P
Swollen glands:	C	P
Tension:	C	P

EYES

Blurry vision:	C	P
Glaucoma:	C	P
Styes:	C	P
Discharge:	C	P
Cataracts:	C	P
Double vision:	C	P
Dark under eyelids:	C	P
Itchy eyes:	C	P
Sensitivity to light:	C	P

EARS

Ear pain:	C	P
Decreased hearing:	C	P
Drainage:	C	P
Ringing:	C	P
Dizziness:	C	P

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NOSE

Frequent colds:	C	P
Congestion:	C	P
Postnasal drip:	C	P
Nasal polyps:	C	P
Seasonal allergies:	C	P
Nosebleeds:	C	P

MOUTH/THROAT

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

RESPIRATORY

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

CARDIOVASCULAR

High blood pressure:	C	P
Low blood pressure:	C	P
Murmurs:	C	P
Arrhythmias:	C	P
Palpitations:	C	P
Chest pain:	C	P
Leg/Feet swelling:	C	P
Rheumatic fever:	C	P

HEMATOLOGIC

Anemia:	C	P
Easy bruising:	C	P
Easy bleeding:	C	P
Transfusions:	C	P

ENDOCRINE

Change in appetite:	C	P
Heat intolerance:	C	P
Cold intolerance:	C	P
Thyroid problems:	C	P
Difficult maintaining weight:	C	P
Diabetes:	C	P

GASTROINTESTINAL

Abdominal pain	C	P
Bowel movement (BM) frequency:	_____	
Diarrhea:	C	P
Constipation:	C	P
Indigestion:	C	P
Recent change in BM:	C	P
Heartburn:	C	P
Bloating:	C	P
Burping/Belching:	C	P
Excess gas:	C	P
Nausea:	C	P
Vomiting:	C	P
Hemorrhoids:	C	P
Gall bladder disease:	C	P
Nausea:	C	P
Liver disease:	C	P
Ulcer:	C	P
Pancreatitis:	C	P

URINARY

Frequent urination	C	P
Incontinence:	C	P
Pain with urination:	C	P
Frequent infections:	C	P
Urgency:	C	P
Discharge/Blood:	C	P
Kidney stones:	C	P

MUSCULOSKELETAL

Weakness:	C	P
Arthritis:	C	P
Stiffness:	C	P
Leg cramps:	C	P
Tremors:	C	P
Joint pain:	C	P

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Muscle pain: C P

FEMALE

Age periods began: _____
Sexual active: C P
Healthy libido: C P
Pain with intercourse: C P
Vaginal dryness: C P
Vaginitis: C P
Sexual orientation:
Hetero Homo Bi
Date of last pap smear: _____
Diagnosis: _____
Any abnormal paps: C P
When was abnormal: _____
Any birth control (BC): C P
Types and ages used:
_____
Sexually transmitted infections: C P
Dexa scan: C P
Results: _____

Menopausal:

Since what age: _____
Any changes in menstrual cycle: C P
Hysterectomy Y N
Use of hormones: C P

If still having period:

Date of last cycle: _____
How often periods occur: _____
How long periods last: _____
Periods:
Light Medium Heavy
Bleeding:
Regular Irregular
Cramping: C P
Pain: C P
PMS: C P
Food cravings: C P

Pregnancy:

Times pregnant: _____
How many births: _____
Caesarian: _____
Vaginal: _____
Miscarriages: _____
Abortions: _____

Breast:

Lumps: C P
Nipple discharge: C P
Self examination: C P
Pain: C P

MALE

Testicular pain/swelling: C P
Hernia: C P
Discharge: C P
Erectile dysfunction: C P
Sexually active: C P
Healthy libido: C P
Prostate disease/symptoms: C P
Sexual orientation:
Hetero Homo Bi
Sexually transmitted infections: C P
Impaired fertility: C P
Last prostate exam: _____

NERVOUS

Paralysis: C P
Tingling/Numbness: C P
Seizures: C P
Sciatica: C P
Carpal tunnel syndrome: C P
Fainting: C P
Nerve pain: C P

MENTAL/EMOTIONAL

Forgetfulness/Memory loss: C P
Sadness: C P
High-strung/Tense: C P
Anger/Irritability: C P
Suicidal: C P
Anxiety: C P
Fear/Panic: C P

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