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:_____

List All Surgeries, Hospitalizations & Traumas—including date occurred:
1. _____ 4. _____
2. _____ 5. _____
3. _____ 6. _____

Please Note When and Why You Had Each of The Following:
X-rays: _____
MRI/Cat Scans:_____
Ultrasounds:_____
Please List All Sensitivities/Allergies/Reactions
Drugs: _____
Foods: _____
Environment: _____

Did you have the following Disease (D), Immunized (I), leave blank if Neither

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

Any vaccination reactions:_____

List Yes (Y) or Past (P), leave unmarked if no regarding use of the following:

Antacids:	Y P	Steroids:	Y P
Smoking:	Y P	Packs per day if Yes/Past:	_____
Analgesics:	Y P	Laxatives:	Y P
Coffee:	Y P	Cups per day if Yes/Past:	_____

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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
Recreational drug treatment: Y P If so, which drugs: _____

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

What do you eat for the following meals?:
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
How much water do you drink? _____
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? _____
_____
Quality of most significant relationship?_____
Who do you live with by relationship? _____

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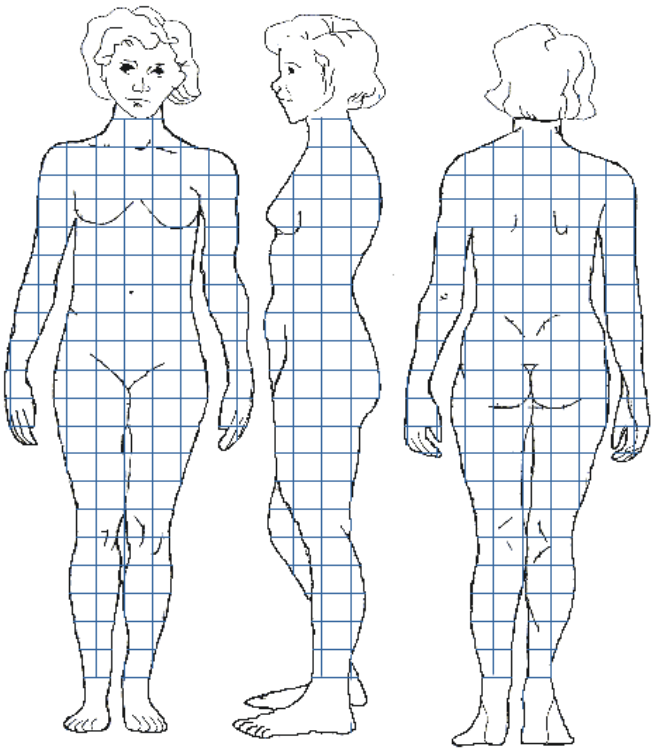
History of sexual, mental/emotional, physical abuse?: Y P
If so, at what age and by whom?: _____
What is your greatest health concern?_____
How does it limit you the most? _____
How committed are you towards making valuable changes: Little Moderately Very

PAIN CHART



Please mark the location of your pain, including any radiation.

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

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REVIEW OF SYSTEMS

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

Please Circle Y if you have the problem **now**, **P** if you had the problem in the **past,** leave blank if you've never had the symptom.
***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
Skin Cancer: Y P

HEAD

Headache: Y P
Head Injury: Y P
Migraine: Y P

EARS

Ear Pain: Y P
Decreased Hearing: Y P
Drainage: Y P
Ringing : 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
Tension: Y P

BREAST

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

EYES

Blurry vision Y P
Blurry vision: Y P
Glaucoma: Y P
Styes: Y P
Discharge : Y P
Cataracts: Y P
Double vision: Y P

Dark under eyelid: Y P
Itchy eyes: Y P

MOUTH/THROUT

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

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Asthma: Y P
Wheezing: Y P
Painful breathing: Y P
Shortness of breath lying down: 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

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

ENDOCRINE

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

URINARY

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

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

Any Birth Control (please list types and ages used):_____
Sexually Transmitted Diseases: Y P
Mammography: Y P

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Dexa Scan: Y P If Yes, what were the results:_____
Use of Hormones: Y P

MUSCULOSKELETAL

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

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