



## Adult Intake Form

Name: \_\_\_\_\_ Date: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_

Date of birth: \_\_\_\_\_ (M/D/Y) Age: \_\_\_\_\_ Gender: \_\_\_\_\_

E-mail: \_\_\_\_\_

Phone: (Home): \_\_\_\_\_ (Cell/Work): \_\_\_\_\_

May we leave phone messages relating to your visits? Y / N

Emergency Contact Name: \_\_\_\_\_ Relationship: \_\_\_\_\_

Phone: \_\_\_\_\_ Address: \_\_\_\_\_

How did you hear about our Clinic? \_\_\_\_\_

If internet: Google: \_\_\_\_ AANP Website: \_\_\_\_ ANMA: \_\_\_\_ Other: \_\_\_\_\_

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. \_\_\_\_\_

## Context of Care

Successful health care and preventative medicine are only possible when the physician has the 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 our understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist 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 0 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?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

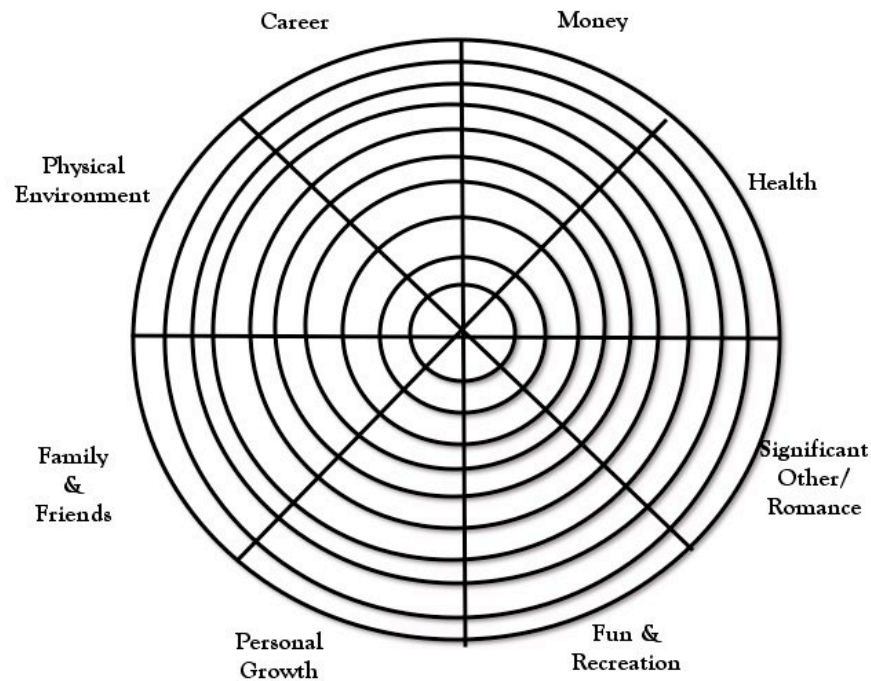
## Context of Care Continued

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.

## 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, continue on back if necessary):

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

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Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

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

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

- |   |  |  |                                      |
|---|--|--|--------------------------------------|
| <input type="checkbox"/> Laxatives                    | <input type="checkbox"/> Pain Relievers        | <input type="checkbox"/> Sleeping Meds                   | <input type="checkbox"/> Antacids    |
| <input type="checkbox"/> Cortisone/Prednisone         | <input type="checkbox"/> Appetite Suppressants | <input type="checkbox"/> Antidepressants                 | <input type="checkbox"/> Antibiotics |
| <input type="checkbox"/> Sedatives                    | <input type="checkbox"/> Thyroid medication    | <input type="checkbox"/> Cholesterol-lowering medication |                                      |
| <input type="checkbox"/> H2 Blockers/Ulcer Medication | <input type="checkbox"/> Birth Control Pills   | <input type="checkbox"/> Hormone Replacement             |                                      |

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.

- |                                    |                                   |   |   |   |
|------------------------------------|-----------------------------------|---|---|---|
| <input type="checkbox"/> Anemia    | <input type="checkbox"/> Cancer   | <input type="checkbox"/> Heart Disease  | <input type="checkbox"/> Mental Illness     | <input type="checkbox"/> Alzheimer's        |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hypertension   | <input type="checkbox"/> Multiple Sclerosis | <input type="checkbox"/> Stroke             |
| <input type="checkbox"/> Asthma    | <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Parkinson's        | <input type="checkbox"/> Other (list below) |

Please list other significant family medical history not listed above:

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## *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

### General

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

### 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

### Endocrine

Hypothyroid?	Y	N	P	S
Hypoglycemia?	Y	N	P	S
Excessive thirst?	Y	N	P	S
Fatigue?	Y	N	P	S

**Endocrine Cont.**

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

**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

**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
Stiffness?	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
Pain or stiffness in neck?	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

**Skin**

Rashes?	Y	N	P	S
Acne/boils?	Y	N	P	S
Change in skin color?	Y	N	P	S
Lumps or bumps in the skin?	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
Shortness of breath lying down?	Y	N	P	S
Painful breathing?	Y	N	P	S
Emphysema?	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? _____				
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

### Mental Emotional Cont.

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

### Female Reproductive Cont.

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
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
Sexual orientation: _____				
Birth control? Type: _____				
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
Sexual orientation: _____				
Birth control? Type: _____				
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
Prostate disease?	Y	N	P	S
Impotence?	Y	N	P	S
Premature ejaculation?	Y	N	P	S