Adult Intake

(Please print clearly)

Name _____ **Date** _____

Date of birth _____ (M/D/Y) **Sex M F**

Address_____

_____

_____

_____

E-mail Address _____

Home Telephone Number _____ **Work** _____

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

Which Phone Number? _____

Emergency contact: Name _____

Phone number _____ **Relation**_____

How did you hear about our Clinic? Please check one of the following:

- ❑ **Media/TV Article**
- ❑ **Corporate Health/Wellness Event**
- ❑ **Clinic staff**
- ❑ **Clinic patient**
- ❑ **Other** _____

Referred by _____

Referred to _____

Other health care providers you are seeing:

1.	2.	3.
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
(_____)_____	(_____)_____	(_____)_____

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

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

If you are female are you currently pregnant? Yes No (Please circle one)

<u>Medical History</u>

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

_____
_____
_____
_____
_____

Do you have any allergies (medicines, environmental, etc.)?

_____
_____
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____
_____
_____
_____

Please list past prescription medications.

_____
_____
_____
_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol—how much/day or week _____
Tobacco—form and amount/day _____
Caffeine—form and amount/day_____
Recreational drugs—what and how often _____

Please indicate what immunizations you have had

☐ **DPT (diphtheria, pertussis, tetanus)**	☐ **Haemophilus influenza B**	☐ **Hepatitis A**
☐ **Tetanus booster; when?** _____	☐ **"Flu"**	☐ **Hepatitis B**
☐ **MMR (measles, mumps, rubella)**	☐ **Polio**	☐ **Smallpox**

Other _____

Please indicate if any caused adverse reactions:

_____

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

Diet

Do you have any food allergies or intolerances? Please list.

_____
_____
_____
_____

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

_____
_____
_____
_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks_____

Beverages (and total quantity)_____

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Please indicate which family member
Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other Mental Illness	
Drug Abuse/Alcoholism	
Kidney Disease	
Other	

- ❑ **I don't know my family medical history**

Environment

Occupation _____
Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

_____
_____
_____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N
Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?

_____
_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____
_____
_____

How would you describe the emotional climate of your home?

_____
_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____
_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____
_____
_____