Adult Intake Form

Name _____ **Date** _____

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

Address: _____

_____

_____

E-mail Address: _____

Home Telephone Number: _____ **(H)**

_____ **(W)**

_____ **(C)**

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

Which Phone Number? _____

Emergency contact information:

Name _____

Phone number _____ **Relation** _____

How did you hear about our Clinic?

_____

_____

_____

_____

If referred by a person, please write name so they can be thanked!

_____

So that we may best co-ordinate care please provide information on 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)

Medical History

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? (Please circle)

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

Please indicate what immunizations you have had:

___ DPT (DIPHTHERIA, PERTUSSIS, TETANUS)
___ HAEMOPHILUS INFLUENZA B
___ HEPATITIS A
___ "FLU"
___ HEPATITIS B
___ TETANUS BOOSTER; WHEN?
___ MMR (MEASLES, MUMPS, RUBELLA)
___ POLIO
___ SMALLPOX
___ CHICKENPOX

Other _____

Please indicate if any caused adverse reactions:

_____

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

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following; Please indicate which family member.
Allergies
Asthma
Other Lung Disease
Heart Disease
High Blood Pressure
Stroke
Cancer
Diabetes
Depression
Alzheimer's
Other Mental Illness
Drug Abuse/Alcoholism
Kidney Disease
Other

Diet & Lifestyle

Do you have any food allergies, sensitivities, 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):_____

Water - how much/day _____

Alcohol - how much/day or week _____

Tobacco - form and amount/day _____

Caffeine - form and amount/day _____

Recreational drugs - what and how often _____

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?

_____
_____
_____
_____