ADULT INTAKE

Patient:____**Date of Birth**_____/_____/_____**Age**_____

REASON FOR VISIT

Please list specific health concerns in order of importance to you:

Concern 1: ____

Date Began: ______/______/______ Have you seen other health care providers for this? Yes No

If yes, what medications or treatments were given:______________________________________

What makes it better?_____________________________Worse?_____________________________

Concern 2: ____

Date Began: ______/______/______ Have you seen other health care providers for this? Yes No

If yes, what medications or treatments were given:______________________________________

What makes it better?_____________________________Worse?_____________________________

Concern 3: ____

Date Began: ______/______/______ Have you seen other health care providers for this? Yes No

If yes, what medications or treatments were given:______________________________________

What makes it better?_____________________________Worse?_____________________________

Do you have any opinions regarding what may have caused your health conditions?_______________________

____

What are some of your expectations of *this* visit?____

____

Do you have any specific goals for your health?____

____

What is your present level of commitment to learn and implement the healthy lifestyle changes that will improve your overall health and well-being?

0% 0 1 2 3 4 5 6 7 8 9 10 100%

Do you have a primary care physician? Yes No

Doctor's Name:____**Phone:**____________________

Location/ Clinic:___________________________**City/State/Zip**_______________________________

List all known ALLERGIES (medication, foods, environment) and reaction:_____________________________

____

HEALTH HISTORY

Date of last physical examination____

Please list past hospitalizations and surgeries:

Have you had removed: ❑Tonsils ❑Appendix ❑Gallbladder ❑Uterus ❑One or both ovaries

Surgery/Hospitalization:____Date:__________
Name/Location of Hospital:__________________________Outcome:__________________________

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Surgery/Hospitalization:____Date:__________
Name/Location of Hospital:__________________________Outcome:__________________________

Any screening exams/tests? **Mammogram** **Colonoscopy** **EEG** **EKG** **MRI** **CT** **X-RAY**

If yes, please list dates and results____

____

MEDICATIONS AND SUPPLEMENTS

Do you take any of the following regularly?

- ❑ Digestive enzymes
- ❑ Aspirin and cold medicines
- ❑ Diet pills
- ❑ Sleeping pills
- ❑ Laxatives
- ❑ Sedatives
- ❑ Cortisone
- ❑ Antacids
- ❑ Thyroid (grains per day____)
- ❑ Estrogen

List all prescription medications that you take, include how long you have been taking:

Med:______________________________ Dosage:________ Times/Day: _______Doctor:______________
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Med:______________________________ Dosage:________ Times/Day: _______Doctor:______________

List all supplements, vitamins, herbs, and homeopathics that you take regularly:

Name & Brand:____ Dosage:_________ Times/Day:________
Reason for Taking:____

Name & Brand:____ Dosage:_________ Times/Day:________
Reason for Taking:____

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Name & Brand:____ Dosage:________ Times/Day:________

Reason for Taking:____

Name & Brand:____ Dosage:________ Times/Day:________

Reason for Taking:____

Name & Brand:____ Dosage:________ Times/Day:________

Reason for Taking:____

HEALTH HABITS

Cigarettes? Yes No If yes, how long?__________How often?____________________ Quit Date:________

Alcohol? Yes No If yes, type:____________________ How often?____________ Quit Date:________

Caffeine? Yes No If yes, type:____________________ How often?__________________________

Soda or Diet Soda? Yes No If yes, type:______________ How often?__________________________

Exercise? Yes No If yes, type:____

How Often?____

DIET

Do you:

- ❑ Feel your diet is adequate
- ❑ Eat at irregular intervals
- ❑ Eat in a hurried atmosphere
- ❑ Eat quickly and forget to chew
- ❑ Drink with meals
- ❑ Eat out often (more than once a week)
- ❑ Eat between meals
- ❑ Follow a special or restricted diet______________
- ❑ Avoid certain foods, if so, what?

____

What have you eaten for breakfast, lunch, dinner, and snacks in the last 24 hours? Include water and other beverage intake.

____

____

____

FAMILY HISTORY

Check boxes if (mother, father, sibling, child, grandparent) has experienced any of the following, indicate who.

- ❑ Diabetes
- ❑ Heart disease
- ❑ Cancer
- ❑ High blood pressure
- ❑ Stroke
- ❑ Mental health issues
- ❑ Asthma
- ❑ Kidney problems
- ❑ Tuberculosis
- ❑ Epilepsy
- ❑ High cholesterol
- ❑ Alcoholism
- ❑ Depression
- ❑ Hives or hay fever
- ❑ Arthritis or gout
- ❑ Thyroid problems
- ❑ Bleeding problems
- ❑ Weight problems

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REVIEW OF SYSTEMS

Height _________Weight _________Weight one year ago? __________Maximum weight ever __________Date_________

What would you estimate your energy level to be on a scale of 1-10?

Poor energy 1 2 3 4 5 6 7 8 9 10 Great energy

On a scale of 1-10 (10 being extreme stress), describe the level of stress you currently experience:

1 2 3 4 5 6 7 8 9 10

Have you had, or do you currently have any of the following:

- ❑ Mumps
- ❑ Measles
- ❑ Rubella
- ❑ Chickenpox
- ❑ Whooping cough
- ❑ Pneumonia
- ❑ Rheumatic
- ❑ Polio
- ❑ Mononucleosis
- ❑ Tuberculosis (TB)
- ❑ Venereal disease (VD)
- ❑ HIV/ AIDS
- ❑ Autoimmune disease
- ❑ Hepatitis
- ❑ Frequent colds or infection
- ❑ Any broken bones
- ❑ Head injury
- ❑ Poisoning of any kind
- ❑ Skin disorders
- ❑ Recurring headaches
- ❑ Glaucoma
- ❑ Asthma
- ❑ Heart problems
- ❑ High blood pressure
- ❑ High cholesterol
- ❑ Peptic ulcer
- ❑ Liver/gallbladder disease
- ❑ Hemorrhoids
- ❑ Kidney problems
- ❑ Arthritis
- ❑ Recurring backache
- ❑ Nervous breakdown
- ❑ Diabetes
- ❑ Thyroid problems
- ❑ Trouble sleeping
- ❑ Insomnia
- ❑ Depression
- ❑ Cancer
- ❑ ____________________
- ❑ ____________________
- ❑ ____________________
- ❑ ____________________
- ❑ ____________________
- ❑ ____________________

Have you been treated for:

- ❑ Alcoholism
- ❑ Drug abuse
- ❑ Eating disorder

WOMEN ONLY

- ❑ Irregular periods
- ❑ Extreme menstrual pain
- ❑ Breast lump
- ❑ Hot flashes at any time
- ❑ Pain during intercourse
- ❑ Any unusual bleeding or discharge
- ❑ Pregnant, or are you possibly pregnant
- ❑ Having problems getting pregnant
- ❑ Using any method of birth control

What kind:______________________

Age onset of menses: ______________

Age at menopause ________________

Usual length of cycle: ___________days

Usual duration of flow: __________days

Date last period began: __________

Date of last PAP: _______________Result:_________

MEN ONLY

- ❑ Pain/ burning with urination
- ❑ Hernias
- ❑ Testicular pain/ masses
- ❑ Prostate problems
- ❑ Impotence/ erectile dysfunction
- ❑ Discharge or sores
- ❑ Using any method of birth control

What kind:________________________

Date of last Prostate exam:_____________________

Date of last PSA:___________Result:___________

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