



Adult Intake Form

Last Name: _____ First Name: _____ Age: _____

DOB: _____

Date: _____

Describe the Reason(s) for Your Visit: _____

What is Your Greatest Health Concern? _____

How Does It Limit You the Most? _____

How Committed Are You Towards Making Valuable Changes: Little Moderately Very

MEDICAL HISTORY:

List Your Medical Diagnoses:

- 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. _____ |

When and What Were the Results of the Following:

Electrocardiogram (ECG): _____

Echocardiogram: _____

Colonoscopy: _____

Mammogram: _____

Please List All Sensitivities/Allergies/Reactions:

Drugs: _____

Foods: _____

Environment: _____

Please Circle ALL that Apply: LEAVE BLANK if you've never had the disease.

Circle D if you had the DISEASE. Circle I if you were IMMUNIZED with vaccinations.

Measles:	D I	Diphtheria:	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

Dinner: _____
Snacks: _____
How much water do you drink per day?: _____
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? _____

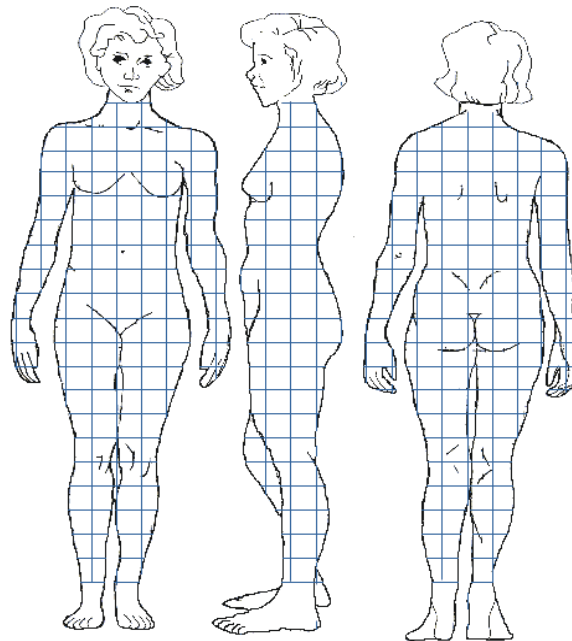
SOCIAL LIFE:

Enjoy job?: Y N Active spiritual practice: Y N
Satisfaction with where you are in life: _____

Stress Level: High Medium Low
Quality of most Significant Relationship: _____
Who do you live with by relationship: _____
History of sexual, mental/emotional/physical abuse?: Y N
If so, at what age and by whom?: _____

PAIN CHART

Please Mark (X) the Location of Your Pain Including Any Radiation.



FAMILY HISTORY:

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age (Living)	_____	_____	_____	_____	_____	_____
Age (Deceased)	_____	_____	_____	_____	_____	_____
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
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
Alzheimer's	Y N	Y N	Y N	Y N	Y N	Y N
Tuberculoses (TB)	Y N	Y N	Y N	Y N	Y N	Y N

REVIEW OF SYSTEMS

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

*Please Circle ALL Symptoms that Apply: LEAVE BLANK if you've never had the symptom.
 Circle C if you have the problem CURRENT. Circle P if you had the problem in the PAST.
 Circle Y for YES. Circle N for NO.*

Good energy: Y N
 Fatigue: Y N
 If fatigued, when is it the worst? Morning Afternoon Evening
 If fatigued, can you do what you need to during the day?: Y N

SKIN

Rash: C P
 Hives: C P
 Lump: C P
 Itchy: C P
 Psoriasis/Eczema: C P
 Skin cancer: C P

EYES

Blurry vision: C P
 Glaucoma: C P
 Styes: C P
 Discharge: C P
 Cataracts: C P
 Double vision: C P
 Dark under eyelids: C P
 Itchy eyes: C P
 Sensitivity to light: C P

HEAD

Headache: C P
 Head injury: C P
 Migraine: C P
 TMJ C P

EARS

Ear pain: C P
 Decreased hearing: C P
 Drainage: C P
 Ringing: C P
 Dizziness: C P

NECK

Stiffness: C P
 Swollen glands: C P
 Tension: C P

NOSE

Frequent colds:	C	P
Congestion:	C	P
Postnasal drip:	C	P
Nasal polyps:	C	P
Seasonal allergies:	C	P
Nosebleeds:	C	P

MOUTH/THROAT

Canker sores:	C	P
Cold sores:	C	P
Sore throat:	C	P
Gum disease:	C	P
Dentures:	C	P
Cavities:	C	P
Loss of taste:	C	P
Hoarseness:	C	P
Dryness	C	P

RESPIRATORY

Cough:	C	P
Shortness of breath with exertion:	C	P
Tuberculosis:	C	P
Bronchitis:	C	P
Pneumonia:	C	P
Asthma:	C	P
Wheezing:	C	P
Painful breathing:	C	P
Shortness of breath: lying down:	C	P

CARDIOVASCULAR

High blood pressure:	C	P
Low blood pressure:	C	P
Murmurs:	C	P
Arrhythmias:	C	P
Palpitations:	C	P
Chest pain:	C	P
Leg/Feet swelling:	C	P
Rheumatic fever:	C	P

HEMATOLOGIC

Anemia:	C	P
Easy bruising:	C	P
Easy bleeding:	C	P
Transfusions:	C	P

ENDOCRINE

Change in appetite:	C	P
Heat intolerance:	C	P
Cold intolerance:	C	P
Thyroid problems:	C	P
Difficult maintaining weight:	C	P
Diabetes:	C	P

GASTROINTESTINAL

Abdominal pain	C	P
Bowel movement (BM) frequency:		
Diarrhea:	C	P
Constipation:	C	P
Indigestion:	C	P
Recent change in BM:	C	P
Heartburn:	C	P
Bloating:	C	P
Burping/Belching:	C	P
Excess gas:	C	P
Nausea:	C	P
Vomiting:	C	P
Hemorrhoids:	C	P
Gall bladder disease:	C	P
Nausea:	C	P
Liver disease:	C	P
Ulcer:	C	P
Pancreatitis:	C	P

URINARY

Frequent urination	C	P
Incontinence:	C	P
Pain with urination:	C	P
Frequent infections:	C	P
Urgency:	C	P
Discharge/Blood:	C	P
Kidney stones:	C	P

MUSCULOSKELETAL

Weakness:	C	P
Arthritis:	C	P
Stiffness:	C	P
Leg cramps:	C	P
Tremors:	C	P
Joint pain:	C	P

Muscle pain: C P

Vaginal: _____
Miscarriages: _____
Abortions: _____

FEMALE

Age periods began: _____
Sexual active: C P
Healthy libido: C P
Pain with intercourse: C P
Vaginal dryness: C P
Vaginitis: C P
Sexual orientation:
Hetero Homo Bi
Date of last pap smear: _____
Diagnosis: _____
Any abnormal paps: C P
When was abnormal: _____
Any birth control (BC): C P
Types and ages used: _____
Sexually transmitted
infections: C P
Dexa scan: C P
Results: _____

Breast:

Lumps: C P
Nipple discharge: C P
Self examination: C P
Pain: C P

MALE

Testicular pain/swelling: C P
Hernia: C P
Discharge: C P
Erectile dysfunction: C P
Sexually active: C P
Healthy libido: C P
Prostate disease/symptoms: C P
Sexual orientation:
Hetero Homo Bi
Sexually transmitted
infections: C P
Impaired fertility: C P
Last prostate exam: _____

Menopausal:

Since what age: _____
Any changes in
menstrual cycle: C P
Hysterectomy Y N
Use of hormones: C P

NERVOUS

Paralysis: C P
Tingling/Numbness: C P
Seizures: C P
Sciatica: C P
Carpal tunnel syndrome: C P
Fainting: C P
Nerve pain: C P

If still having period:

Date of last cycle: _____
How often periods occur: _____
How long periods last: _____
Periods:
Light Medium Heavy
Bleeding:
Regular Irregular
Cramping: C P
Pain: C P
PMS: C P
Food cravings: C P

MENTAL/EMOTIONAL

Forgetfulness/Memory loss: C P
Sadness: C P
High-strung/Tense: C P
Anger/Irritability: C P
Suicidal: C P
Anxiety: C P
Fear/Panic: C P

Pregnancy:

Times pregnant: _____
How many births: _____
Caesarian: _____