



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 Check ALL that Apply: LEAVE BLANK if you've never had the disease.
 Check DISEASE if you had the DISEASE. Check IMMUNIZED if IMMUNIZED with vaccinations.*

CONDITION	DISEASE	IMMUNIZED
COVID-19	<input type="checkbox"/>	<input type="checkbox"/>
Measles	<input type="checkbox"/>	<input type="checkbox"/>
Mumps	<input type="checkbox"/>	<input type="checkbox"/>

CONDITION	DISEASE	IMMUNIZED
Rubella	<input type="checkbox"/>	<input type="checkbox"/>
Chickenpox	<input type="checkbox"/>	<input type="checkbox"/>
German measles	<input type="checkbox"/>	<input type="checkbox"/>
Influenza	<input type="checkbox"/>	<input type="checkbox"/>
Diphtheria	<input type="checkbox"/>	<input type="checkbox"/>
Tetanus	<input type="checkbox"/>	<input type="checkbox"/>
Whooping Cough	<input type="checkbox"/>	<input type="checkbox"/>
Hemophylis (Hib)	<input type="checkbox"/>	<input type="checkbox"/>
Hepatitis B	<input type="checkbox"/>	<input type="checkbox"/>
Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>

Any Vaccination Reactions?:

SUBSTANCES:

Mark ALL that Apply: LEAVE BLANK if you've never had the symptom.

Check C if you CURRENTLY use the following substances. Check P if you have in the PAST.

<u>SUBSTANCE</u>	<u>C</u>	<u>P</u>
Antacids:	<input type="checkbox"/>	<input type="checkbox"/>
Steroids:	<input type="checkbox"/>	<input type="checkbox"/>
Analgesics:	<input type="checkbox"/>	<input type="checkbox"/>
Laxatives:	<input type="checkbox"/>	<input type="checkbox"/>
Coffee:	<input type="checkbox"/>	<input type="checkbox"/>
Cups per day:	_____	
Soda:	<input type="checkbox"/>	<input type="checkbox"/>
Ounces per day:	_____	
Energy drinks:	<input type="checkbox"/>	<input type="checkbox"/>
Tobacco:	<input type="checkbox"/>	<input type="checkbox"/>
Packs per day:	_____	

<u>SUBSTANCE</u>	<u>C</u>	<u>P</u>
E-cigarette:	<input type="checkbox"/>	<input type="checkbox"/>
Marijuana/CBD:	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drugs:	<input type="checkbox"/>	<input type="checkbox"/>
Drug addiction:	<input type="checkbox"/>	<input type="checkbox"/>
Recreational drug treatment:	<input type="checkbox"/>	<input type="checkbox"/>
Type of drugs:	_____	
Alcohol:	<input type="checkbox"/>	<input type="checkbox"/>
How much per day:	_____	
Alcohol addiction:	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol treatment:	<input type="checkbox"/>	<input type="checkbox"/>

List all CURRENT Prescription Medicines, Supplements, & Herbs You Take:

Name of Supplement/Medication	Dosage	Reason(s) for Taking Supplement/Medication	Does It Help? (Yes or No)

HEALTH HABITS

EXERCISE:

How often?: _____

What type(s)?: _____

How long?: _____

HOBBIES: _____

SLEEP:

How long per night (hours): _____

Work: Day Shift OR Night Shift

If you wake up frequently, what is the reason: _____

Mark ALL that Apply: LEAVE BLANK if you've never had the symptom.

SLEEP	C	P	SLEEP	C	P
Trouble falling asleep:	<input type="checkbox"/>	<input type="checkbox"/>	Have you had a sleep study:	<input type="checkbox"/>	<input type="checkbox"/>
Trouble staying asleep:	<input type="checkbox"/>	<input type="checkbox"/>	Tired/Fatigued/Sleepy		
Wake unrefreshed:	<input type="checkbox"/>	<input type="checkbox"/>	during the day:	<input type="checkbox"/>	<input type="checkbox"/>
Snore loudly:	<input type="checkbox"/>	<input type="checkbox"/>	Stop breathing during sleep:	<input type="checkbox"/>	<input type="checkbox"/>
Sleep apnea:	<input type="checkbox"/>	<input type="checkbox"/>	Grind teeth:	<input type="checkbox"/>	<input type="checkbox"/>

MEALS:

Meals per day: _____

How much water do you drink per day?: _____

Other beverages?: _____

What do you eat for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

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? _____

DENTAL HYGIENE:

When was your last dental cleaning?: _____

How often do you have dental cleanings?: _____

Do you have root canals?: Yes No If so, how many?: _____

Do you have Amalgam fillings?: Yes No If so, how many?: _____

SOCIAL LIFE:

Enjoy job?: Yes No Active spiritual practice: Yes No

Satisfaction with where you are in life: _____

Stress Level: High Medium Low

Quality of most Significant Relationship: _____

Who do you live with by relationship: _____

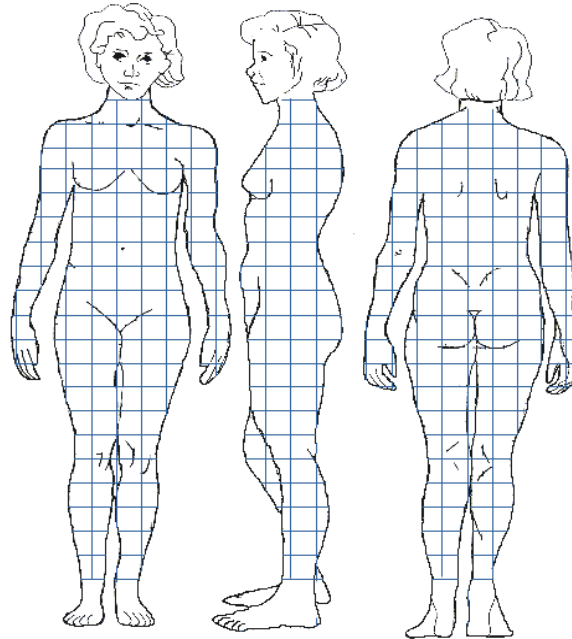
Do you have a network of supportive family/friends?: Yes No

History of sexual, mental/emotional/physical abuse?: Yes No

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)	_____	_____	_____	_____	_____	_____

Check Y for YES. CHECK N for NO.

High blood pressure	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart attack/Stroke	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Heart disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Asthma/Allergies	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Mental illness	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Auto-immune disease	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Diabetes Mellitus	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Osteoporosis	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Alzheimer's	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Tuberculosis (TB)	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N	<input type="checkbox"/> Y <input type="checkbox"/> N
Any other conditions?:	_____					

REVIEW OF SYSTEMS

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

Please Mark ALL Symptoms that Apply: LEAVE BLANK if you've never had the symptom. Check C if you have the problem CURRENT. Check P if you had the problem in the PAST. Check Y for YES. Check 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

NOSE

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

HEAD

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

MOUTH/THROAT

Canker sores: C P
 Cold sores: C P
 Sore throat: C P
 Loss of taste: C P
 Hoarseness: C P
 Dryness: C P

NECK

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

DENTAL HYGIENE :

Gum disease: C P
 Dentures: C P
 Cavities: 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

RESPIRATORY

Cough: 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
 Shortness of breath
 sitting: C P
 Shortness of breath
 with exertion: C P

EARS

Ear pain: C P
 Decreased hearing: C P
 Drainage: C P
 Ringing: C P
 Dizziness: 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
 Difficulty 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
 Liver disease: C P
 Ulcer: C P
 Pancreatitis: C P
 Change in appetite: 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

NERVOUS

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

MENTAL/EMOTIONAL

Forgetfulness or 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

FEMALE

Age periods began: _____

Sexual active: C P

Healthy libido: C P

Hot flashes: C P

Insomnia: 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: _____

Abnormal paps: C P

When: _____

Birth control (BC): C P

Types and ages used: _____

Use of hormones: C P

Sexually transmitted infections: C P

Dexa scan: C P

Results: _____

Menopausal:

Since what age: _____

Any changes in menstrual cycle: C P

Hysterectomy: Yes No

How were/are they being treated: _____

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

Pregnancy:

Times pregnant: _____

How many births: _____

Caesarian: _____

Vaginal: _____

Miscarriages: _____

Abortions: _____

Breast:

Lumps: C P

Nipple discharge: C P

Self examination: C P

Breast pain: C P

MALE

Testicular pain or swelling: C P

Hernia: C P

Discharge: C P

Difficulty achieving erection: C P

Difficulty maintaining erection: C P

Waking erection regularly: C P

Sexually active: C P

Healthy libido: C P

Prostate disease or symptoms: C P

Sexual orientation:
 Hetero Homo Bi

Sexually transmitted infections: C P

Impaired fertility: C P

Last prostate exam: _____