Adult Intake

(please print clearly)

Name _____ **Date** _____

Date of birth _____ (mm/dd/yyyy) **Sex M F**

Address:_____

_____

E-mail Address: _____

Telephone: Home: _____ **Work**:_____ Cell:_____

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

Emergency contact: Name: _____

Phone number: _____**Relation**: _____

How did you hear about our Clinic: _____

Referred by: _____

Other health care providers you are seeing:

1. _____	**2.** _____	**3.** _____
_____	_____	_____
_____	_____	_____
(____)_____	**(____)**_____	**(____)**_____

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

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

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

Food	Environmental	Medicine

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

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

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.

Condition	Date

Current/past medications (please fill in attached chart)

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: _____

Diet

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

Intolerances	Restricitons

Family history

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

	Who?		Who?
Allergies		**Depression**	
Asthma		**Other mental illness**	
Heart disease		**Drug abuse**	
High blood pressure		**Alcoholism**	
Cancer		**Kidney disease**	
Diabetes		**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

On a scale of 1 to 5 how would you rate the emotional climate of your home?

(Hostile) 1 2 3 4 5 (Peaceful)

On a scale of 1 to 5 how stressful is your work?

(Not at all) 1 2 3 4 5 (Very)

On a scale of 1 to 5 how stressful are other aspects of your life?

(Not at all) 1 2 3 4 5 (Very)

Rate how well you handle these stresses?

(Not well at all) 1 2 3 4 5 (Very)

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

_____

_____

_____

_____

_____

_____

For file use only.