Adult Intake

(please print clearly)

Name: ____ Date: ________

Date of birth: ______________________ (M/D/Y) Age: _____ Sex: M F

Address: ____

____

E-mail address: ____

Telephone number: Home: __________________ Work: __________________

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

Emergency contact:

Name: ____

Phone number: _________________ Relation: ___________________________

How did you hear about our clinic? ____________________________________

Other health care providers you are seeing:

1.__________________ 2__________________ 3. __________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

(_____)______________ (_____)______________ (_____)______________

What are your health concerns? Please list in order of importance to you:

1.____
2.____
3.____
4.____
5.____

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

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

Medical history:

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, accidents, injuries, surgeries and hospitalizations; along with approximate dates:

____
____
____
____
____

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

____
____
____
____

Please list all current medications: (prescription, over-the-counter, vitamins, herbs, homeopathic remedies, etc.)

____
____
____
____

Please list past prescription medications:

____
____
____
____
____
____

How many times have you been treated with antibiotics? ____________________

How frequently do you use any of the following? (Please circle and indicate how often)

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)
- ☐ MMR (measles, mumps, rubella)
- ☐ Tetanus booster; when? ___________________________
- ☐ Haemophilus influenza B
- ☐ "Flu"
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox
- ☐ Other ____

Please indicate if any immunization caused adverse reactions:

____

____

Diet:

Do you have any food allergies 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) ____

Family history:

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

Condition	Who?	Condition	Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Kidney disease	
High blood pressure		Drug abuse/alcoholism	
Cancer		Other	
Diabetes			

Additional comments: ____

____

____

☐ 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

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?

____
____
____
____

For file use only.