

Adult Health Intake

Name: _____ Date of Birth: _____ Sex: M F Age: _____

Blood Type: _____ Occupation: _____ Last Grade School Completed: _____

Health Concerns: Please list in order of importance. Rate severity (1 is low, 10 is high) and success (1 is no success, 10 is very successful).

Concern	Severity (1-10)	Past/Present Treatments	Success Level (1-10)

Are you currently under the care of a physician? Yes/No

Specialty: _____

If yes, with whom? What condition? _____

If no, when did you last receive medical care? _____

When was your last physical exam? _____

Do you have a known infectious disease at this time? Yes/No If yes, what? _____

Do you have any known drug or food allergies? _____

Medications/Supplements

Please list all medications and vitamins/supplements you are currently taking in the following table:

Current

Name	Strength	Dosage	Reason	Duration

Past (Within last six months, circle any that apply)

- | | | | | |
|----------------|-----------------------|-----------|-----------|---------------|
| Pain Relievers | Appetite suppressants | Hormones | Sedatives | Thyroid |
| Antacids | Birth control | Insulin | Sleeping | Tranquilizers |
| Antibiotics | Blood pressure | Laxatives | Steroids | Supplements: |

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Social History

With whom do you live? _____ Pets? _____ Indoor/Outdoor

Have you lived or traveled outside of the United States? _____ If so, when and where? _____

Typical Breakfast		Time
Lunch		Time
Dinner		Time
Snacks		

Food	Servings per Week	Food	Servings per Week
Beef		Fresh Fruit	
Poultry Light		Fresh Vegetables	
Dark		Breads, cereals, grains, pasta	
Lamb		Legumes	
Fish		Seeds	
Pork		Nuts/Nut Butters	
Tofu/Soy Products		Butter (sticks/week)	
Eggs (#/week)		Oils:	
Yogurt %fat			
Protein Powder (type)			
Cottage Cheese %fat		Sweets (cookies, cakes, candy)	
Cheese (oz servings)			

Cravings? _____ Dietary restrictions or food aversions? _____

Time in between meals? _____ Water intake: # _____ oz/day

Do you purchase organic fruits and vegetables? Yes/No/Some Do you purchase organic meat and dairy? Yes/No/ Some

Beverages (specify type):

Alcohol: _____ Coffee/Tea: _____ Soda: Diet/Regular Milk: _____ %fat

Have you dieted in the past? _____ Total pounds lost throughout your life dieting: _____

Do you use tobacco? Yes/No/ Past Quantity: _____ Do you use recreational drugs? Yes/No

Do you exercise? Yes/No What kind? _____ Frequency? _____ Duration? _____

Interests and hobbies: _____

Do you watch television? Yes/No Hours/Night? _____ Do you take vacations? Yes/No Week (s) off/year: _____

Describe your work: _____

Do you have a supportive relationship? Yes/No Married/Divorced/Single/Separated/Widowed

How important is spirituality or religion in your life? _____

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Sleep

Hours/night: _____ Wake refreshed? Yes/No Fall asleep easily (within 5 min.)? Yes/No
 Wake to urinate? Yes/No Wake at other time: _____ Do you snore? Yes/No
 Do you stop breathing during sleep? _____ Concerns about sleep: _____
 Energy (scale of 1-10, 10 is the best): _____ Stress (scale of 1-10, 10 is most severe): _____

Family History

	Age if Living	Age of Death	Health Problems (please list any cancers, cardiovascular disease, diabetes, thyroid or osteoporosis)
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Spouse			
Children			

Personal History

<i>Childhood illnesses</i>	Yes, Had Disease	No, Never Had	Vaccinated
Scarlet Fever			
Mumps			
Diphtheria			
Rheumatic Fever			
German Measles			
Measles			

<i>Childhood illnesses</i>	Yes, Had Disease	No, Never Had	Vaccinated
Chicken Pox			
Shingles			
Smallpox			
Rubella			
Pertussis			
Other			

Vaccine reactions: _____
 Other Vaccinations (circle) Polio Tetanus Flu
 Previous medical diagnosis or conditions: _____

Hepatitis B Meningitis HPV

Adult Health Intake

Surgeries, Hospitalizations and Procedures

Surgery	Year	Reason
Appendectomy		
Tonsillectomy		
Dental		
Gallbladder		
Hernia		
Other		
Do you have any artificial joints or other implants? Yes No Type?		
Hospitalizations	Year	Reason
Diagnostic Procedures	Year	Reason
Colonoscopy		
Mammography		
Ultrasound		
X-Ray		
DEXA (Bone Scan)		
CT/MRI		Location?

Allergies

	Type	Reaction
Medications		
Foods		
Environmental		

Environmental History

Please indicate (X) if you have any current or past exposure to the items listed in the following table:

Household	Current	Past	Reaction
Leaded paint			
Near refinery or industrial area			
New Carpet/Paint/Other Remodeling			
Pesticide/Insecticide Use			
Dry Cleaning			
Live in a Smoking Home			
Work			
Solvent Exposure			
Heavy Metals			
Fumes			
Chemicals			
Work in Smoking Environment			

Household	Current	Past	Reaction
Sensitivities			
Perfumes			
Detergents			
Gas or other Vapors			
Other			
Radiation			
Infectious			
Do you have metal or mercury fillings? Yes No			
Number?			
Done after 1976? Yes No			
Date of last filling:			
How many removed?			
Root canals currently?			
Root canals removed?			

Review of Systems

Please **CIRCLE** from the following options:

Yes (Y)= A condition you have **now** or in the **past 6 months**, No (N)=never had, Past (P)= A condition you had in the past (**longer than 6 months ago**)

<u>Cold Hands and Feet</u>	Y	N	P	<u>Vertigo or Dizziness</u>	Y	N	P	<u>Eye Conjunctivitis</u>	Y	N	P
<u>Daytime Sleepiness</u>	Y	N	P	<u>Loss of Balance</u>	Y	N	P	<u>Crusting</u>	Y	N	P
<u>Difficulty Falling/Staying Asleep</u>	Y	N	P	<u>Fainting</u>	Y	N	P	<u>Impaired Vision</u>	Y	N	P
<u>Early Waking</u>	Y	N	P	<u>Lightheadedness</u>	Y	N	P	<u>Eye Pain/Strain</u>	Y	N	P
<u>Fever</u>	Y	N	P	<u>Loss of Consciousness</u>	Y	N	P	<u>Glasses/Contacts</u>	Y	N	P
<u>Flushing</u>	Y	N	P	<u>Nerve Pain</u>	Y	N	P	<u>Tearing or Dryness</u>	Y	N	P
<u>Sleepwalking</u>	Y	N	P	<u>Tremor</u>	Y	N	P	<u>Double Vision</u>	Y	N	P
<u>Nightmares</u>	Y	N	P	<u>Rash</u>	Y	N	P	<u>Glaucoma</u>	Y	N	P
<u>No Dream Recall</u>	Y	N	P	<u>Eczema</u>	Y	N	P	<u>Cataracts</u>	Y	N	P
<u>Snoring</u>	Y	N	P	<u>Hives</u>	Y	N	P	<u>Eyelid Redness</u>	Y	N	P
<u>Chronic Fatigue</u>	Y	N	P	<u>Acne</u>	Y	N	P	<u>Vision Problems</u>	Y	N	P
<u>Chronic Infection</u>	Y	N	P	<u>Boils</u>	Y	N	P	<u>Muscle Twitch in Eye</u>	Y	N	P
<u>Enlarged/Tender Lymph Nodes</u>	Y	N	P	<u>Itching</u>	Y	N	P	<u>Impaired Hearing</u>	Y	N	P
<u>Slow Wound Healing</u>	Y	N	P	<u>Skin Color Change</u>	Y	N	P	<u>Ringing or Noise in Ear</u>	Y	N	P
<u>Chemical/Metal/Drug Poisoning</u>	Y	N	P	<u>Perpetual Hair Loss</u>	Y	N	P	<u>Earaches</u>	Y	N	P
<u>Hyper/Hypo (circle) Thyroid</u>	Y	N	P	<u>Head Lumps</u>	Y	N	P	<u>Dizziness</u>	Y	N	P
<u>Hot/Cold (circle) Intolerance</u>	Y	N	P	<u>Athletes Foot</u>	Y	N	P	<u>Ear Fullness</u>	Y	N	P
<u>Night Sweats</u>	Y	N	P	<u>Cellulite</u>	Y	N	P	<u>Other Ear Pain</u>	Y	N	P
<u>Hyper/Hypo (circle)glycemia</u>	Y	N	P	<u>Dark Circles Under Eyes</u>	Y	N	P	<u>Sensitivity to Loud Noise</u>	Y	N	P
<u>Diabetes</u>	Y	N	P	<u>Ears/Face (circle) Red</u>	Y	N	P	<u>Frequent Sore Throats</u>	Y	N	P
<u>Excess Thirst</u>	Y	N	P	<u>Moles with Color or Size</u>	Y	N	P	<u>Excess Saliva</u>	Y	N	P
<u>Excess Hunger</u>	Y	N	P	<u>Shange</u>				<u>Dry Mouth</u>	Y	N	P
<u>Fatigue</u>	Y	N	P	<u>Oily Skin</u>	Y	N	P	<u>Teeth Grinding</u>	Y	N	P
<u>Agoraphobia</u>	Y	N	P	<u>Pale Skin</u>	Y	N	P	<u>Gum Problems</u>	Y	N	P
<u>Auditory/Visual (circle)</u>	Y	N	P	<u>Psoriasis</u>	Y	N	P	<u>Hoarseness</u>	Y	N	P
<u>Hallucinations</u>				<u>Sensitive to Bites</u>	Y	N	P	<u>Sore Tongue</u>	Y	N	P
<u>Treatment for Emotional Problem</u>	Y	N	P	<u>Shingles</u>	Y	N	P	<u>Coating on Tongue</u>	Y	N	P
<u>Difficulty Concentrating</u>	Y	N	P	<u>Skin Cancer</u>	Y	N	P	<u>Loss of Taste</u>	Y	N	P
<u>Mood Swings</u>	Y	N	P	<u>Skin Darkening</u>	Y	N	P	<u>TMJ Problems</u>	Y	N	P
<u>Considered/Attempted (circle) Suicide</u>	Y	N	P	<u>Strong Body Odor</u>	Y	N	P	<u>Teeth Problems</u>	Y	N	P
<u>Memory problems</u>	Y	N	P	<u>Thick Calluses</u>	Y	N	P	<u>Bleeding Gums</u>	Y	N	P
<u>Depression</u>	Y	N	P	<u>Vitiligo</u>	Y	N	P	<u>Canker Sores</u>	Y	N	P
<u>Anxiety/Nervousness</u>	Y	N	P	<u>Nails Bitten</u>	Y	N	P	<u>Cold Sores</u>	Y	N	P
<u>Panic Attacks</u>	Y	N	P	<u>Brittle</u>	Y	N	P	<u>Cracking at Corner of Lips</u>	Y	N	P
<u>Fearfulness</u>	Y	N	P	<u>Curve Up</u>	Y	N	P	<u>Dentures</u>	Y	N	P
<u>Irritability</u>	Y	N	P	<u>Frayed</u>	Y	N	P	<u>Periodontal Diseases</u>	Y	N	P
<u>Phobias</u>	Y	N	P	<u>Fungus</u>	Y	N	P	<u>Neck Lumps</u>	Y	N	P
<u>Paranoia</u>	Y	N	P	<u>Pitting</u>	Y	N	P	<u>Swollen Glands</u>	Y	N	P
<u>Seizures</u>	Y	N	P	<u>Ragged Cuticles</u>	Y	N	P	<u>Goiter/Enlarged Thyroid</u>	Y	N	P
<u>Paralysis</u>	Y	N	P	<u>Ridges</u>	Y	N	P	<u>Neck Pain or Stiffness</u>	Y	N	P
<u>Muscle Weakness</u>	Y	N	P	<u>Thickening</u>	Y	N	P	<u>Nose Stuffiness</u>	Y	N	P
<u>Numbness</u>	Y	N	P	<u>Toenail Problems</u>	Y	N	P	<u>Sinus Fullness</u>	Y	N	P
<u>Tingling</u>	Y	N	P	<u>White Spots/Lines</u>	Y	N	P	<u>Nose Bleeds</u>	Y	N	P
<u>Loss of Memory</u>	Y	N	P	<u>Headache</u>	Y	N	P	<u>Loss of Smell</u>	Y	N	P
				<u>Migraine</u>	Y	N	P	<u>Sinus Infection</u>	Y	N	P
				<u>Tension Headache</u>	Y	N	P	<u>Postnasal Drip</u>	Y	N	P
				<u>Head Injury</u>	Y	N	P	<u>Bad Breath</u>	Y	N	P
				<u>Concussion</u>	Y	N	P	<u>Sore throat</u>	Y	N	P
				<u>Jaw/TMJ Problems</u>	Y	N	P	<u>Odor in Nose</u>	Y	N	P

Review of Systems

Dry/Productive (circle) Cough	Y	N	P
Sputum	Y	N	P
Spitting up Blood	Y	N	P
Wheezing	Y	N	P
Asthma	Y	N	P
Allergies	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Pleurisy	Y	N	P
Emphysema	Y	N	P
Pain on Breathing	Y	N	P
Shortness of Breath	Y	N	P
Positive TB Test	Y	N	P
Heart Disease	Y	N	P
Angina	Y	N	P
High Blood Pressure	Y	N	P
Low Blood Pressure	Y	N	P
Murmurs	Y	N	P
Irregular Pulse	Y	N	P
Blood Clots	Y	N	P
Chest Pain	Y	N	P
Phlebitis	Y	N	P
Palpitations/Fluttering	Y	N	P
Rheumatic Fever	Y	N	P
Swelling in Knees/ Ankles/Feet (circle)	Y	N	P
Stroke	Y	N	P
Valve Prolapse	Y	N	P
Easy Bleeding/Bruising	Y	N	P
Anemia	Y	N	P
Deep Leg Pain	Y	N	P
Varicose Veins	Y	N	P
Thrombophlebitis	Y	N	P
Anal Spasm	Y	N	P
Anal Fissures	Y	N	P
Trouble Swallowing	Y	N	P
Dry Mouth	Y	N	P
Heartburn	Y	N	P
Change in Thirst	Y	N	P
Change in Appetite	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Blood in Stool	Y	N	P
Mucus in Stool	Y	N	P
Constipation	Y	N	P

Diarrhea	Y	N	P
Black Stools	Y	N	P
Pain or Cramps	Y	N	P
Gallbladder Disease	Y	N	P
Belching	Y	N	P
Gas	Y	N	P
Bloating	Y	N	P
Ulcer	Y	N	P
Jaundice (yellow skin)	Y	N	P
Hemorrhoids	Y	N	P
Liver Disease	Y	N	P
Food Intolerance			
Lactose	Y	N	P
Gluten	Y	N	P
Corn	Y	N	P
Eggs	Y	N	P
Fatty Food	Y	N	P
Yeast	Y	N	P
Pain on Urination	Y	N	P
Burning on Urination	Y	N	P
Increased Frequency	Y	N	P
Increased Urgency	Y	N	P
Frequent Urination at Night	Y	N	P
Incontinence	Y	N	P
Bedwetting	Y	N	P
Hesitancy	Y	N	P
Frequent Infection	Y	N	P
Kidney Disease	Y	N	P
Kidney Stones	Y	N	P
Blood in Urine	Y	N	P
Bladder Pressure	Y	N	P
Urine Odor	Y	N	P
Urethra Pain	Y	N	P
Irritation	Y	N	P
Itching	Y	N	P
Low Libido	Y	N	P
Sexual Difficulty	Y	N	P
Sexually Transmitted Disease	Y	N	P

MALE			
Urination Difficulty	Y	N	P
Diagnosed with prostate issue or elevated PSA	Y	N	P
Swelling or lumps on testicles	Y	N	P
Testicular Pain	Y	N	P
Other:			

FEMALE			
Age at Menarche:			
Date of last menses:			
Abnormal Vaginal Discharge	Y	N	P
Vaginal Odor	Y	N	P
Vaginal Itching	Y	N	P
Vaginal Pain	Y	N	P
Endometriosis	Y	N	P
Fibroids	Y	N	P
Ovarian Cysts	Y	N	P
Sexually Active	Y	N	P
Pain During Intercourse	Y	N	P
Regular Cycles	Y	N	P
Bleeding Between Cycles	Y	N	P
Painful Menses	Y	N	P
Clots	Y	N	P
Abnormal Pap	Y	N	P
Number of Pregnancies			
Number of Miscarriages			
Number of Abortions			
Difficulty Conceiving	Y	N	P
Breast Lumps	Y	N	P
Breast Cysts	Y	N	P
Breast Pain/Tenderness	Y	N	P
Nipple Discharge	Y	N	P
Muscle Spasm	Y	N	P
Joint Pain	Y	N	P
Joint Stiffness	Y	N	P
Joint Deformity	Y	N	P
Joint Redness	Y	N	P
Arthritis	Y	N	P
Broken Bones	Y	N	P
Muscle Weakness	Y	N	P
Muscle Cramps	Y	N	P
Muscle Pain	Y	N	P
Muscle Stiffness	Y	N	P
Back Pain	Y	N	P
Tendonitis	Y	N	P

Additional Concerns: