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
Antacids
Antibiotics
Appetite suppressants
Birth control
Blood pressure
Hormones
Insulin
Laxatives
Sedatives
Sleeping
Steroids
Thyroid
Tranquilizers
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

Childhood illnesses	Yes, Had Disease	No, Never Had	Vaccinated
Scarlet Fever			
Mumps			
Diptheria			
Rheumatic Fever			
German Measles			
Measles			

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

Vaccine reactions: ________________________________

Other Vaccinations (circle) Polio Tetanus Flu Hepatitis B Meningitis HPV

Previous medical diagnosis or conditions:____

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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?

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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**)

Condition			
Cold Hands and Feet	Y	N	P
Daytime Sleepiness	Y	N	P
Difficulty Falling/Staying Asleep	Y	N	P
Early Waking	Y	N	P
Fever	Y	N	P
Flushing	Y	N	P
Sleepwalking	Y	N	P
Nightmares	Y	N	P
No Dream Recall	Y	N	P
Snoring	Y	N	P
Chronic Fatigue	Y	N	P
Chronic Infection	Y	N	P
Enlarged/Tender Lymph Nodes	Y	N	P
Slow Wound Healing	Y	N	P
Chemical/Metal/Drug Poisoning	Y	N	P
Hyper/Hypo (circle) Thyroid	Y	N	P
Hot/Cold (circle) Intolerance	Y	N	P
Night Sweats	Y	N	P
Hyper/Hypo (circle)glycemia	Y	N	P
Diabetes	Y	N	P
Excess Thirst	Y	N	P
Excess Hunger	Y	N	P
Fatigue	Y	N	P
Agoraphobia	Y	N	P
Auditory/Visual (circle) Hallucinations	Y	N	P
Treatment for Emotional Problem	Y	N	P
Difficulty Concentrating	Y	N	P
Mood Swings	Y	N	P
Considered/Attempted (circle) Suicide	Y	N	P
Memory problems	Y	N	P
Depression	Y	N	P
Anxiety/Nervousness	Y	N	P
Panic Attacks	Y	N	P
Fearfulness	Y	N	P
Irritability	Y	N	P
Phobias	Y	N	P
Paranoia	Y	N	P
Seizures	Y	N	P
Paralysis	Y	N	P
Muscle Weakness	Y	N	P
Numbness	Y	N	P
Tingling	Y	N	P
Loss of Memory	Y	N	P

Condition			
Vertigo or Dizziness	Y	N	P
Loss of Balance	Y	N	P
Fainting	Y	N	P
Lightheadedness	Y	N	P
Loss of Consciousness	Y	N	P
Nerve Pain	Y	N	P
Tremor	Y	N	P
Rash	Y	N	P
Eczema	Y	N	P
Hives	Y	N	P
Acne	Y	N	P
Boils	Y	N	P
Itching	Y	N	P
Skin Color Change	Y	N	P
Perpetual Hair Loss	Y	N	P
Head Lumps	Y	N	P
Athletes Foot	Y	N	P
Cellulite	Y	N	P
Dark Circles Under Eyes	Y	N	P
Ears/Face (circle) Red	Y	N	P
Moles with Color or Size Shange	Y	N	P
Oily Skin	Y	N	P
Pale Skin	Y	N	P
Psoriasis	Y	N	P
Sensitive to Bites	Y	N	P
Shingles	Y	N	P
Skin Cancer	Y	N	P
Skin Darkening	Y	N	P
Strong Body Odor	Y	N	P
Thick Calluses	Y	N	P
Vitiligo	Y	N	P
Nails Bitten	Y	N	P
Brittle	Y	N	P
Curve Up	Y	N	P
Frayed	Y	N	P
Fungus	Y	N	P
Pitting	Y	N	P
Ragged Cuticles	Y	N	P
Ridges	Y	N	P
Thickening	Y	N	P
Toenail Problems	Y	N	P
White Spots/Lines	Y	N	P
Headache	Y	N	P
Migraine	Y	N	P
Tension Headache	Y	N	P
Head Injury	Y	N	P
Concussion	Y	N	P
Jaw/TMJ Problems	Y	N	P

Condition			
Eye Conjunctivitis	Y	N	P
Crusting	Y	N	P
Impaired Vision	Y	N	P
Eye Pain/Strain	Y	N	P
Glasses/Contacts	Y	N	P
Tearing or Dryness	Y	N	P
Double Vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Eyelid Redness	Y	N	P
Vision Problems	Y	N	P
Muscle Twitch in Eye	Y	N	P
Impaired Hearing	Y	N	P
Ringing or Noise in Ear	Y	N	P
Earaches	Y	N	P
Dizziness	Y	N	P
Ear Fullness	Y	N	P
Other Ear Pain	Y	N	P
Sensitivity to Loud Noise	Y	N	P
Frequent Sore Throats	Y	N	P
Excess Saliva	Y	N	P
Dry Mouth	Y	N	P
Teeth Grinding	Y	N	P
Gum Problems	Y	N	P
Hoarseness	Y	N	P
Sore Tongue	Y	N	P
Coating on Tongue	Y	N	P
Loss of Taste	Y	N	P
TMJ Problems	Y	N	P
Teeth Problems	Y	N	P
Bleeding Gums	Y	N	P
Canker Sores	Y	N	P
Cold Sores	Y	N	P
Cracking at Corner of Lips	Y	N	P
Dentures	Y	N	P
Periodontal Diseases	Y	N	P
Neck Lumps	Y	N	P
Swollen Glands	Y	N	P
Goiter/Enlarged Thyroid	Y	N	P
Neck Pain or Stiffness	Y	N	P
Nose Stuffiness	Y	N	P
Sinus Fullness	Y	N	P
Nose Bleeds	Y	N	P
Loss of Smell	Y	N	P
Sinus Infection	Y	N	P
Postnasal Drip	Y	N	P
Bad Breath	Y	N	P
Sore throat	Y	N	P
Odor in Nose	Y	N	P

Review of Systems

Item	Y	N	P
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

Item	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

Item	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:

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