



## Adult Intake

### PATIENT INFORMATION

Full Name: \_\_\_\_\_ Date: \_\_\_\_\_

Day/Month/Year

Date of Birth: \_\_\_\_\_

Day/Month/Year

Gender: Male Female Transgendered

Ethnicity: \_\_\_\_\_

### CONTACT INFORMATION

Full Address: \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

Telephone: (home) \_\_\_\_\_ (work) \_\_\_\_\_

(mobile) \_\_\_\_\_

Email: \_\_\_\_\_

Emergency Contact: \_\_\_\_\_

Relationship: \_\_\_\_\_

(\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_ (\_\_\_\_\_) \_\_\_\_\_  
Telephone (home) Work Mobile / Pager

Marital Status (circle): Single Married Divorced Separated Living with Partner Widowed

Do you have any children? Y N

If yes, list age and gender. \_\_\_\_\_

Name of Medical Doctor: \_\_\_\_\_ Tel: (\_\_\_\_\_) \_\_\_\_\_

Address: \_\_\_\_\_ Fax:(\_\_\_\_\_) \_\_\_\_\_

Date of last visit to Medical Doctor: \_\_\_\_\_ Date last physical: \_\_\_\_\_

Are you under the care of any other health care providers (Please list names, specialty, phone number)?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How did you hear of this clinic/who were you referred by? \_\_\_\_\_

Occupation? \_\_\_\_\_

Any occupational hazards? \_\_\_\_\_

## CONTEXT OF CARE

1. Why did you choose to come to this clinic, and what do you know about our approach?

2. What three expectations do you have from your visit to our clinic?

3. What long term expectations do you have from working with us?

4. What is your present level of commitment to addressing any underlying causes of your signs and symptoms that relate to your diet and lifestyle? (Rate from 1 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

5. a) Please list the behaviors or lifestyle habits that you currently engage in *regularly*, that you believe support your health:

b) Please list the behaviors or lifestyle habits that you currently engage in *regularly* that you believe are obstacles to achieving your health goals:

6. Who do you know that will *sincerely and consistently* support you in the beneficial lifestyle changes you will be making?

7. What do you LOVE to do?

**MEDICAL HISTORY**

Please list your chief health concerns in order of importance to you.

Concern	Since
1.	
2.	
3.	
4.	
5.	

What effect have these issues had on your life?

How would you describe your general state of health?

Please list any major trauma, injury, illness or accident (mental, emotional or physical) you have sustained.

Incident	Date	Long-term effects

Please list any surgical procedures you have undergone.

Procedure	Date	Complications / Results

Please list any other forms of treatment that you have used and describe their effectiveness.

**CHILDHOOD ILLNESSES & VACCINATIONS:**(circle all that apply & indicate "I" for illness & "V" for vaccination):

- |                |               |               |                          |          |
|----------------|---------------|---------------|--------------------------|----------|
| Chicken pox    | Measles       | Mumps         | Rheumatic Fever          | Roseola  |
| Polio          | Scarlet fever | Tuberculosis  | Whooping Cough           | Impetigo |
| Ear Infections | Strep Throat  | Mononucleosis | Rubella (German measles) |          |

Followed childhood vaccination schedule?  
Any known side effects to any vaccinations?

Any additional vaccinations (i.e. Hepatitis A or B, "Flu shot", etc)?

**MEDICATIONS / SUPPLEMENTS / DRUGS**

Please list all **current** medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug / Supplement (Company & Brand Name)	Used For	Date Started	Dosage / Frequency

In the last 5 years, about how many courses of antibiotics have you taken?  
Most recent course?

**Which of the following have you used / do your currently use? Include amount, frequency, duration.**

Tobacco	Alcohol
Recreational Drugs	Steroids
Cortisone	Antacids
Sedatives	Laxatives
Coffee	Other

**ALLERGIES, SENSITIVITIES, EXPOSURES**

Please list any known or suspected allergies, sensitivities and/or intolerances.

Drugs	Food	Environmental/Chemical

**FAMILY HISTORY**

Please indicate if any of your immediate family (parents, siblings, maternal & paternal grandparents) suffers from or has suffered from any of the following conditions.

Condition	Family Member(s)	Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism/ Drug use		Colitis		Kidney Disease	
Allergies / hay fever		Depression/ mental health		Liver Disease	
Asthma		Diabetes		Overweight / obesity	
Arthritis		Heart Disease		Osteoporosis	
Breast Cancer		High Blood Pressure		Prostate Cancer	
Colon Cancer		Thyroid disease		Stroke	

Any other conditions?

**DIET & DIGESTION**

Height: \_\_\_\_\_ Current Weight: \_\_\_\_\_ Desired weight if different? \_\_\_\_\_

Maximum weight? \_\_\_\_\_ when? \_\_\_\_\_ Minimum weight? \_\_\_\_\_ when? \_\_\_\_\_

Have you gained or lost any weight in the past 6-12 months? Y N

If so, how much? \_\_\_\_\_ Gained or lost? \_\_\_\_\_ Was this intentional? \_\_\_\_\_

Are there any foods you exclude from your diet? For what reason?

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy)

How much water do you drink daily?

What is the primary source of your drinking water (bottled, filtered, tap, well, etc)?

What other beverages do you drink, and how much?

How often do you urinate? Every \_\_\_\_ hr(s)

How often do you have a bowel movement (per day or week)?

**Please fill out the attached diet diary prior to your first visit and return with intake form when completed.**

## LIFESTYLE FACTORS

On a scale of 1-10, (10 = highest) rate your energy: \_\_\_\_\_ /10 rate your stress level: \_\_\_\_\_ /10

What time of day is your energy the best? \_\_\_\_\_ worst? \_\_\_\_\_

What affects your energy? (increases or decreases)

Do you exercise regularly? Y N

What forms of exercise?

What duration/intensity/frequency?

What are your interests/hobbies?

How often do you enjoy them?

## SLEEP

What time do you typically get into bed?

How long does it take you to fall asleep?

Do you wake during the night?

If so:

- How often?
- At what time(s)?
- What wakes you?
- How long does it typically take you to fall back asleep?

What time do you typically wake?

Do you require an alarm clock to wake up?

Do you experience difficulty in waking up?

How would you rate your overall quality of sleep, on average out of 10?

(0 = total insomnia/almost no sleep, 10 = deep, undisturbed sleep, wake naturally & easily) \_\_\_\_\_/10

Do you use any sleep aids (over-the-counter, or prescribed)?

If so:

- What type/amount?
- How often?

How old is your mattress and what condition is it in?

What position do you sleep in?

## Do you currently suffer from any of the following? (check all that apply & circle specific concerns)

- Pain (arthritis, muscle aches, injury, back problems, etc)
- Lung Disease, Asthma, Difficulty breathing, Sleep Apnea
- Heart Disease
- Menopause: hot flashes, heart palpitations, night sweats
- Metabolic Disease: diabetes, hyperthyroidism
- Digestive Disorders: reflux, heartburn, constipation, diarrhea, colitis, etc
- Infection: fever, cough, nasal or sinus congestion
- Leg cramps, Restless Leg Syndrome
- Mental illnesses, Mood disorders, Increased stress, Anxiety
- Some prescription medications
- Disrupted Schedule/Circadian Rhythm: travel, shift work, overwork/overtime, irregular schedule
- Use of Stimulants or Habitual Use of Depressants: alcohol, recreational drugs, caffeine, nicotine, thyroid hormones, anti-hypertensive drugs, bronchodilators i.e. asthma drugs
- Poor Sleep Habits: clock watching, worry about falling asleep, staying up too late, stimulating activities 1-2 hours before bedtime (TV, exercise, work, computer), weekend excessive sleep, caffeine too close to bed, thinking about work or problems while lying in bed, low level of physical activity during the day
- Recent Stressful Event or Trauma (physical, mental or emotional)
- Bedroom not dark enough (can see your hand held in front of your face)

**FEMALE (if applicable)**

Age at menarche (first menses)? \_\_\_\_\_ Age at menopause (if reached)? \_\_\_\_\_

Number of days for typical menstrual flow (include spotting and bleeding)? \_\_\_\_\_

Number of days in menstrual cycle (from first day to the following first day)? \_\_\_\_\_

Date of last menses? \_\_\_\_\_

Number of pregnancies? \_\_\_\_\_ Number of live births? \_\_\_\_\_

Any history of miscarriage, abortion, c-section, breech birth, twins?

With any previous pregnancies, were there any difficulties or complications to pregnancy or delivery?

**Is there any chance you are pregnant now?** Y N

Are you currently lactating? Y N

Do you perform regular (monthly) self breast exams?  
Any history of breast lumps or masses?

Do you go for a yearly PAP test? Y N

Date of last PAP test?

Any history of irregular PAP test (please explain)?

Date of last physical exam?

Date of last screening lab work?

**MALE (if applicable)**

Do you go to a doctor or ND for an annual physical exam? Y N

Date of last physical exam?

Do you get regular screening lab tests? Y N

Last DRE (digital rectal exam)?

Any irregularities found?

**ADDITIONAL**

Is there any other information relevant to your health that has not been addressed?

**Thank you for taking the time to complete this intake form. It's completion will help us to understand your whole health picture, and to provide you with the best care possible.**