

adult intake form

PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR INITIAL APPOINTMENT (please print carefully)

Name: _____ Today's Date: _____

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

Address: _____

Telephone number: (H): _____ (W): _____

May we leave messages relating to your visits? Yes No

Emergency contact name: _____

Contact's phone number: _____ Relation: _____

Referred by: _____

Other health care providers you are seeing:

What are your health concerns, in order of importance:

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

If you are female, are you currently pregnant? Yes No Not sure

medical history _____

*Please note that all information supplied will be kept strictly confidential.

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.

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

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

Approximately, how many times have you been treated with antibiotics? _____

Do you frequently use any of the following?

Aspirin Laxatives Antacids Diet pills Birth control pills implants injections

Alcohol—how many units per day or week _____

Nicotine —form and amount per day or week _____

Caffeine—form and amount per day or week _____

medical history cont.

Recreational drugs— form and amount per day or week _____

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

Do you have any food allergies or intolerances? If so, please list.

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

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

Please indicate which family member

- | | |
|---|--|
| <input type="checkbox"/> Allergies _____ | <input type="checkbox"/> Diabetes _____ |
| <input type="checkbox"/> Asthma _____ | <input type="checkbox"/> Cancer _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Depression _____ |
| <input type="checkbox"/> Drug/Alcohol Dependency _____ | <input type="checkbox"/> Heart Disease _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Other _____ |
| <input type="checkbox"/> I don't know my family medical history | |

Please indicate what immunizations you have had

- | | |
|---|--|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> "Flu" Shot | <input type="checkbox"/> MMR (measles, mumps, rubella) |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Smallpox |
| <input type="checkbox"/> Tetanus booster; when? | <input type="checkbox"/> Other |

Please indicate if any caused adverse reactions:

medical history cont.

Occupation: _____

Do you exercise regularly? Y N If so, 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 at home, etc.) Y N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

Do you have any hobbies? If so, what are they?

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

