Intake Information

Name: _____ Occupation: _____

Age: _____

Date of Birth: _____ Emergency Contact:

Year/Month/Day Name: _____

Address: _____ Phone No. _____

_____ Address: _____

_____ _____

Phone: (H) _____

(W) _____

(C)_____

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

If so, which phone number ?_____

Email address: _____

Marital/Relationship Status: _____

Who referred you to the clinic and/or where did you hear about the clinic?

_____

Please list the medical professionals you currently see:

_____

_____

_____

_____

What are your health concerns, in order of importance to you:

_____

_____

_____

_____

_____

_____

_____

_____

_____

Please list any serious conditions, illnesses, or surgeries/hospitalizations:

Condition	Year
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Allergies:

_____

(chemical/drug)

_____

(food)

_____

(other)

Number and Age of Siblings:

_____

_____

Indicate if a close relative (parent, child, or sibling) has had any of the following. Please indicate which family member:

diabetes _____
heart problems _____
thyroid problems _____
cancer _____
psychiatric problems _____
lung problems _____
smokers _____
gallbladder problems _____
others _____

arthritis _____
high blood pressure _____
glaucoma _____
kidney problems _____
tuberculosis _____
strokes _____
alcohol problems _____
liver problems _____

Please list all current medications (prescriptions, over-the-counter, vitamins, herbs, homeopathics, etc.), including dose:

_____

_____

_____

_____

_____

_____

Please list any past prescription medications:

_____

_____

_____

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

How many times have you been treated with antibiotics?

_____

_____

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when?
- ☐ MMR (measles, mumps, rubella)
- ☐ Haemophilus influenza B
- ☐ Flu
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox
- ☐ Other _____

Please indicate any adverse reactions:

_____

_____

Do you frequently use any of the following?

- ☐ Painkillers
- ☐ Muscle Relaxers
- ☐ Laxatives
- ☐ Antacids
- ☐ Diet Pills

Please list any traumas (physical and/or emotional):

_____

_____

How many hours of sleep do you get a night? _____ Do you wake up often? Y / N

If so what times? _____

Do you smoke? Y / N If yes, for how long? _____

Do you exercise? Y / N If yes, how much and how often?

_____

_____

Are you exposed to significant tobacco smoke? Y / N

Are you frequently exposed to animals (work, pets, etc.) ? Y / N

Are you frequently exposed to toxins or other hazards (home, work, 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 do you handle these stresses?

_____

_____

_____

Describe a typical day's diet:
Breakfast:_____
Snack:_____
Lunch:_____
Snack:_____
Dinner:_____
Snack:_____
Beverages (and total quantity):_____
Alcohol:_____
Caffeine:_____

Do you have any dietary restrictions?

_____
_____

Thank you for taking the time to fill out this form. If there is anything else you would like to add please do so, your concerns and information are important to your case.

_____
_____
_____
_____
_____
_____
_____