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**ADULT INTAKE**

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone # (home): _____(cell)_____ (work): _____

Email address: _____

Age: _____ Date of Birth: _____ Gender: F/M Education:_____

Married:____ Separated:____ Divorced:____ Widowed:____ Single:____ Partnership:_____

Live with: Spouse:____ Partner:____ Parents:____ Children:____ Friends:____ Alone:____

Occupation: _____ Hours per week: _____

Employer Name and Address: _____

_____

How did you hear about this clinic? Another practitioner _____ ND directory _____

Friend/family member _____ Google search Brochure/Business Card Public Presentation

Professional Seminar Other_____

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

_____

**CONTEXT OF CARE REVIEW**

Successful health care and preventive medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

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## CONTEXT OF CARE REVIEW (continued)

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

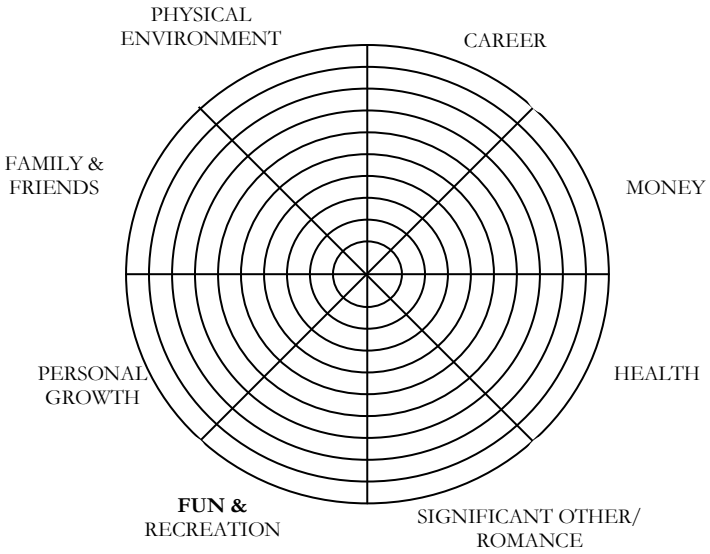
What do you love to do?

## WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.




Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

_____

## FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

| | | | |
|---|---|---|---|
| Cancer | Diabetes | Heart Disease | High Blood Pressure |
| Kidney disease | Epilepsy | Arthritis | Glaucoma |
| Tuberculosis | Stroke | Anemia | Mental Illness |
| Asthma | Hay fever | Hives | |

Any other relevant family history? _____
What is your family heritage? _____

## CHILDHOOD ILLNESSES

Birth city & state: _____ Birth time (if known): _____ Birth weight:_____

Please circle whether you had any of the following as a child:

| | | | |
|---|---|---|---|
| Rheumatic fever | Diphtheria | Scarlet fever | Chicken pox |
| German Measles | Measles | Mumps | |

## HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

## ALLERGIES

Are you hypersensitive or allergic to:

Any drugs? _____

Any foods? _____

Any environmentals or chemicals? _____

## CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

| | | | |
|---|---|---|---|
| Laxatives | Pain relievers | Antacids | Cortisone |
| Antibiotics | Tranquilizers | Sleeping Pills | Thyroid Medication |
| Birth Control Pills | Hormone Replacement | | |

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

**GENERAL**

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? _____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

**TYPICAL FOOD INTAKE**

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

To drink: _____

**FOR THE FOLLOWING, PLEASE CIRCLE:**

**Y**=yes/condition you have now **N**=no/never had **P**= problem in the past

**GENERAL**

| | | | |
|---|---|---|---|
| Do you sleep well? | Y | N | P |
| Average 6-8 hours? | Y | N | P |
| Awake rested? | Y | N | P |
| Have a supportive relationship? | Y | N | P |
| Have a history of abuse? | Y | N | P |
| Experienced a major trauma? | Y | N | P |
| Use recreational drugs? | Y | N | P |
| Treated for drug dependence? | Y | N | P |
| Use alcoholic beverages? | Y | N | P |
| Use tobacco? | Y | N | P |

If in the past, how many years? _____

How many packs per day? _____

| | | | |
|---|---|---|---|
| Do you enjoy your work? | Y | N | P |
| Take vacations? | Y | N | P |
| Spend time outside? | Y | N | P |
| Eat three meals a day? | Y | N | P |
| Do you go on diets often? | Y | N | P |
| Do you eat out often? | Y | N | P |
| Do you drink coffee? | Y | N | P |
| Drink black/green tea? | Y | N | P |
| Drink soda? | Y | N | P |
| Do you eat refined sugar? | Y | N | P |
| Do you add salt to your food? | Y | N | P |

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**NEUROLOGIC**

| | | | |
|---|---|---|---|
| Seizures? | Y | N | P |
| Muscle weakness? | Y | N | P |
| Loss of memory? | Y | N | P |
| Vertigo or dizziness? | Y | N | P |
| Paralysis? | Y | N | P |
| Numbness or tingling? | Y | N | P |
| Easily stressed? | Y | N | P |
| Loss of balance? | Y | N | P |

**ENDOCRINE**

| | | | |
|---|---|---|---|
| Hypothyroid? | Y | N | P |
| Hypoglycemia? | Y | N | P |
| Excessive thirst? | Y | N | P |
| Fatigue? | Y | N | P |
| Heat or cold intolerance? | Y | N | P |
| Hyperthyroid? | Y | N | P |
| Diabetes? | Y | N | P |
| Excessive hunger? | Y | N | P |
| Seasonal depression? | Y | N | P |
| Difficulty exercising? | Y | N | P |

**IMMUNE**

| | | | |
|---|---|---|---|
| Reactions to immunizations? | Y | N | P |
| Chronically swollen glands? | Y | N | P |
| Slow wound healing? | Y | N | P |
| Chronic fatigue syndrome? | Y | N | P |
| Chronic infections? | Y | N | P |
| Night sweats? | Y | N | P |

**EARS**

| | | | |
|---|---|---|---|
| Impaired hearing? | Y | N | P |
| Ringing in ears? | Y | N | P |
| Dizziness? | Y | N | P |
| Ear aches? | Y | N | P |

**EYES**

| | | | |
|---|---|---|---|
| Impaired vision? | Y | N | P |
| Cataracts? | Y | N | P |
| Glaucoma? | Y | N | P |
| Spots in vision? | Y | N | P |
| Color blindness? | Y | N | P |
| Tearing or dryness? | Y | N | P |
| Eye pain or strain? | Y | N | P |

**HEAD**

| | | | |
|---|---|---|---|
| Headaches? | Y | N | P |
| Migraines? | Y | N | P |
| Head injury? | Y | N | P |
| Jaw or TMJ problems? | Y | N | P |

**NOSE AND SINUS**

| | | | |
|---|---|---|---|
| Frequent colds? | Y | N | P |
| Stuffiness? | Y | N | P |
| Sinus problems? | Y | N | P |
| Nose bleeds? | Y | N | P |
| Hayfever? | Y | N | P |
| Loss of smell? | Y | N | P |

**NECK**

| | | | |
|---|---|---|---|
| Lumps in neck? | Y | N | P |
| Goiter? | Y | N | P |
| Difficulty swallowing? | Y | N | P |
| Pain or stiffness in neck? | Y | N | P |

**MOUTH AND THROAT**

| | | | |
|---|---|---|---|
| Frequent sore throat? | Y | N | P |
| Copious saliva? | Y | N | P |
| Sore tongue or lips? | Y | N | P |
| Hoarseness? | Y | N | P |
| Jaw clicks? | Y | N | P |
| Teeth grinding? | Y | N | P |
| Gum problems? | Y | N | P |
| Dental cavities? | Y | N | P |

**SKIN**

| | | | |
|---|---|---|---|
| Rashes? | Y | N | P |
| Acne/boils? | Y | N | P |
| Change in skin color? | Y | N | P |
| Lumps or bumps on skin? | Y | N | P |
| Eczema or hives? | Y | N | P |
| Itching? | Y | N | P |
| Perpetual hair loss? | Y | N | P |

**RESPIRATORY**

| | | | |
|---|---|---|---|
| Cough? | Y | N | P |
| Sputum? | Y | N | P |
| Asthma? | Y | N | P |
| Wheezing? | Y | N | P |
| Bronchitis? | Y | N | P |
| Coughing up blood? | Y | N | P |
| Shortness of breath? | Y | N | P |
| Shortness of breath when lying down? | Y | N | P |
| Pain in breathing? | Y | N | P |
| Emphysema? | Y | N | P |
| Tuberculosis? | Y | N | P |

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## GASTROINTESTINAL

| | | | |
|---|---|---|---|
| Trouble swallowing? | Y | N | P |
| Change in thirst? | Y | N | P |
| Change in appetite? | Y | N | P |
| Nausea/vomiting? | Y | N | P |
| Ulcer? | Y | N | P |
| Jaundice? | Y | N | P |
| Gall bladder disease? | Y | N | P |
| Liver disease? | Y | N | P |
| Hemorrhoids? | Y | N | P |
| Pancreatitis? | Y | N | P |
| Heartburn? | Y | N | P |
| Abdominal pain or cramps? | Y | N | P |
| Belching or passing gas? | Y | N | P |
| Constipation? | Y | N | P |

Bowel movements: how often? _____

Is this a change?_____

| | | | |
|---|---|---|---|
| Black stools? | Y | N | P |
| Blood in stools? | Y | N | P |

## MENTAL/EMOTIONAL

| | | | |
|---|---|---|---|
| Treated for emotional problem? | Y | N | P |
| Depression? | Y | N | P |
| Anxiety or nervousness? | Y | N | P |
| Poor concentration? | Y | N | P |
| Do you have mood swings? | Y | N | P |
| Considered suicide? | Y | N | P |
| Attempted suicide? | Y | N | P |
| Tension? | Y | N | P |
| Memory problems? | Y | N | P |

## URINARY

| | | | |
|---|---|---|---|
| Increased frequency of urination? | Y | N | P |
| Inability to hold urine? | Y | N | P |
| Pain in urination? | Y | N | P |
| Frequency at night? | Y | N | P |
| Frequent UTI's? | Y | N | P |
| Kidney stones? | Y | N | P |

## MUSCULOSKELETAL

| | | | |
|---|---|---|---|
| Joint pain or stiffness? | Y | N | P |
| Arthritis? | Y | N | P |
| Broken bones? | Y | N | P |
| Weakness? | Y | N | P |
| Muscle spasms or cramps? | Y | N | P |
| Sciatica? | Y | N | P |

## BLOOD

| | | | |
|---|---|---|---|
| Anemia? | Y | N | P |
| Easy bleeding or bruising? | Y | N | P |
| Cold hands/feet? | Y | N | P |
| Deep leg pain? | Y | N | P |
| Thrombophlebitis? | Y | N | P |
| Varicose veins? | Y | N | P |

## CARDIOVASCULAR

| | | | |
|---|---|---|---|
| High Blood Pressure? | Y | N | P |
| Heart Palpitations? | Y | N | P |
| Angina? | Y | N | P |
| Rheumatic fever? | Y | N | P |
| Murmurs? | Y | N | P |
| Swelling in ankles? | Y | N | P |
| Heart Disease? | Y | N | P |
| Heart Attack? | Y | N | P |

## FEMALE REPRODUCTIVE

Age of first menses:_____

Age of last menses (if menopausal):_____

Length of cycle:_____days

Duration of menses:_____days

| | | | |
|---|---|---|---|
| Are your cycles regular? | Y | N | P |
| Painful menses? | Y | N | P |
| Heavy or excessive flow? | Y | N | P |
| PMS? | Y | N | P |

Symptoms:_____

_____

| | | | |
|---|---|---|---|
| Bleeding between cycles? | Y | N | P |
| Clotting? | Y | N | P |
| Endometriosis? | Y | N | P |
| Ovarian cysts? | Y | N | P |
| Vaginal odor? | Y | N | P |
| Vaginal discharge? | Y | N | P |

Date of last pap smear:_____

| | | | |
|---|---|---|---|
| Abnormal PAP? | Y | N | P |
| Cervical dysplasia? | Y | N | P |
| Are you sexually active? | Y | N | P |

Sexual orientation:_____

Birth control? Type:_____

| | | | |
|---|---|---|---|
| Pain during intercourse? | Y | N | P |
| Gonorrhea? | Y | N | P |
| Herpes? | Y | N | P |
| Chlamydia? | Y | N | P |
| Genital warts? | Y | N | P |
| Syphilis? | Y | N | P |

**FEMALE REPRODUCTIVE (continued)**

| | | | |
|---|---|---|---|
| Difficulty conceiving? | Y | N | P |
| Number of pregnancies:_____ | | | |
| Number of live births:_____ | | | |
| Number of miscarriages:_____ | | | |
| Number of abortions:_____ | | | |
| Do you do self breast exams? | Y | N | P |
| Breast pain/tenderness? | Y | N | P |
| Breast lumps? | Y | N | P |
| Nipple discharge? | Y | N | P |
| Menopausal symptoms? | Y | N | P |

**MALE REPRODUCTIVE**

| | | | |
|---|---|---|---|
| Are you sexually active? | Y | N | P |
| Sexual orientation:_____ | | | |
| Birth control? Type:_____ | | | |
| Discharge or sores? | Y | N | P |
| Chlamydia? | Y | N | P |
| Gonorrhea? | Y | N | P |
| Genital warts? | Y | N | P |
| Herpes? | Y | N | P |
| Syphilis? | Y | N | P |
| Hernias? | Y | N | P |
| Testicular masses? | Y | N | P |
| Testicular pain? | Y | N | P |
| Prostate disease? | Y | N | P |
| Impotence? | Y | N | P |
| Premature ejaculation? | Y | N | P |