



ADULT INTAKE FORM

Name _____ Date _____

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

Address: _____

Town/City: _____ Province: _____ Postal Code: _____

E-mail Address: _____

Telephone number: Home: _____ Work: _____

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

Emergency contact

Name: _____

Phone number: _____ Relation: _____

How did you hear about our Clinic?: _____

Referred by: _____

Other health care providers you are seeing:

1. _____ 2. _____ 3. _____

Chief Concern:

How long has this condition persisted? _____

Previous Treatments and Results _____

Other health concerns, in order of importance to you:

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

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate past serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

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

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

Please list **past** prescription medications

How many times have you been treated with antibiotics?

Do you frequently use any of the following? (circle)

Aspirin / Tylenol / Laxatives / Antacids / Diet pills /

Birth control pills/implants/injections _____

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often? _____

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"/> Tetanus booster; when? _____	<input type="checkbox"/> "Flu"	<input type="checkbox"/> Hepatitis B
<input type="checkbox"/> MMR (measles, mumps, rubella)	<input type="checkbox"/> Polio	<input type="checkbox"/> Smallpox

Other

Please indicate if any caused adverse reactions:

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

Diet

Do you have any food allergies or intolerances? Please list.

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

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Family history

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

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug abuse/alcoholism	
Heart disease		Thyroid Condition	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

How many hours of sleep do you get a night?:

Do you wake up through the night? Y / N If so, at what time?:

How would you describe the emotional climate of your home?

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

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

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

How is your home heated?

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

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