

INITIAL INTAKE FORM

Date: _____

Last Name: _____ First Name: _____ Female Male:

How would you prefer to be addressed in our office? _____ Birth date: _____ Age: _____

Address: _____ City: _____

Postal Code: _____ Home Phone: _____ Business Phone: _____

Profession: Full or part: _____ Employer: _____

Check one: Married Widowed Single Divorced Separated

Number of children: _____ Referred to this office by: _____

Medical CareCard Number. _____

Person to notify incase of emergency: _____ Relationship: _____

Address: _____ Phone: _____

CURRENT HEALTH CONDITION:

1. What health concerns/problems brought you to this office? _____

2. Has anything recently changed or become worse? _____

3. Is a physician treating you for any condition now? _____

CURRENT MEDICATIONS:

Please include all of your prescription medications (sleeping biUs. birth control pills. etc.), non-prescription medications (aspirin, antacids, etc), vitamins. herbs, etc.

KNOWN ALLERGIES: (such as medications. pollens, foods, etc.) _____

HOSPITALIZATIONS. SURGERIES OR SERIOUS INJURIES:

Date and reason of hospitalization: _____

Height: _____ Current Weight: _____ lbs. 1 year ago: _____ lbs. Max Weight: _____ 19 _____

Smoker: Yes No Smoked _____ years Amount per day: _____ Year stopped: _____

Alcohol use: Yes No Type: _____ Frequency: _____

Recreational drug use: Yes No Type: _____ Frequency: _____

Coffee: Yes No _____ cups per day Tea: Yes No _____ cups per day

Diet: Any food groups that you avoid: Yes No Which ones: _____

Regular exercise: Yes No Type: _____

Duration: _____ Frequency: _____

Women: Are you currently pregnant? Yes No Not Sure

Do you currently take any vitamins or minerals? Yes No

Do you think you may need to take vitamins or minerals? Yes No

MEDICAL HISTORY: Please check only those that pertain to **YOU** personally.

- Alcohol abuse
- Gallbladder/liver
- Arthritis
- Headaches
- Blood pressure problems/stroke
- Hypoglycemia
- Cold, flu, sore throat
- Lung problems
- Ear problems
- Edema
- Skin Problems
- Psychological difficulties, suicide/depression
- STD (herpes, Chlamydia, gonorrhea)
- Occupational exposure to toxic substances
- Female gynecological problems
- Fever
- Anemia
- Hay Fever
- Bleeding problems
- Hepatitis
- Colitis
- Joint problems
- Digestive disturbances
- Eating disorders
- Eye Problems
- Epilepsy
- Allergies
- Gum/teeth problems
- Asthma
- Heart Disorders
- Cancer
- Jaundice
- Diabetes
- Kidney problems
- Parasites
- Thyroid
- Ulcer

FAMILY MEDICAL HISTORY: Blood relatives **NOT** including yourself

- Asthma
- High blood pressure
- Cancer
- Obesity
- Epilepsy
- Tuberculosis
- Heart Problems
- Bleeding problems
- Mental disorders
- Eating disorders
- Substance abuse
- Hayfever, allergies
- Arthritis
- Kidney problems
- Diabetes
- Stroke
- Gout
- Thyroid problems