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Adult Intake Form

Patient Information

Date_____

Name_____

Address_____

_____

Age _____ DOB _____

Phone _____

Email_____

May we contact you by email? Yes No

Emergency Contact:

Name_____

Relation_____

Phone_____

Health History

What are your primary health concerns or treatment goals?

1)_____

2)_____

3)_____

Please list any current medications or supplements you may be taking:

_____

_____

_____

Please list any previous hospitalizations, surgeries, or significant illnesses:

_____

_____

General Diet:

Vegetarian Vegan Omnivore Other

Please check any conditions that have occurred in family members:

- ❑ Diabetes
- ❑ High Blood Pressure
- ❑ Cardiovascular Disease
- ❑ Cancer
- ❑ Mental Health Conditions

Other_____

Please check any conditions you have, or have had in the past:

- ❑ Anemia
- ❑ Allergies or sensitivities: _____
- ❑ Arthritis
- ❑ Cancer
- ❑ Diabetes
- ❑ HIV
- ❑ Hepatitis
- ❑ Mental Health Conditions: _____

Please check any general symptoms you have experienced in the past year:

- ❑ Notable weight loss or gain
- ❑ Irritability
- ❑ Nervousness or anxiety
- ❑ Excessive Fear
- ❑ Excessive Anger
- ❑ Excessive Worry
- ❑ Excessive Joy
- ❑ Feelings of Sadness or Depression
- ❑ Feeling Overwhelmed
- ❑ Easily Startled
- ❑ Headaches / Migraines
- ❑ Notable Hair Loss
- ❑ Fatigue
- ❑ Difficulty Focusing
- ❑ Poor Memory or Concentration
- ❑ Night Sweats or Excessive Sweating

How would you currently rate your energy levels	Low 0—1—2—3—4—5—6—7—8—9—10 High
Are you, or may you be Pregnant?	Yes No

Review of Systems

Please check any Symptoms you have experienced <u>at any time in your history:</u>

Musculoskeletal:
- ❑ Tremors or Cramps
- ❑ Swollen Joints
- ❑ Pain or Weakness of Muscles

Cardiovascular:
- ❑ Chest Pain
- ❑ Poor Circulation
- ❑ Swelling of Hands, Ankles, Feet
- ❑ Irregular Heart Beats
- ❑ Dizziness or Shortness of Breath

Eyes, Ears, Nose, Throat, Respiratory:
- ❑ Asthma or Wheezing
- ❑ Allergies
- ❑ Blurred Vision or Visual Changes
- ❑ Eye Pain
- ❑ Loss of Hearing
- ❑ Earaches
- ❑ Ringing in the Ears
- ❑ Sore Throat

Immune:
- ❑ Frequent Colds, Flus, or Infections
- ❑ Swollen Glands
- ❑ Long Recovery Following Infections

Skin:
- ❑ Poor Wound Healing
- ❑ Easy or Unexplained Bruising
- ❑ Rashes
- ❑ Eczema
- ❑ Psoriasis
- ❑ Itching
- ❑ Dryness
- ❑ Frequent or Recurring Skin Infections

Digestion:
- ❑ Gas or Bloating
- ❑ Abdominal Pain or Cramping
- ❑ Heartburn / Acid Reflux
- ❑ Difficulty Swallowing
- ❑ Nausea or Vomiting
- ❑ Poor Appetite
- ❑ Excessive Appetite
- ❑ Loose Stools or Diarrhea
- ❑ Undigested Food in Stool
- ❑ Blood or Mucus in the Stool
- ❑ Constipation or Difficulty Passing Stool
- ❑ Irregular Bowel Movements
- ❑ Pain or Itching of the Anus

Sleep:
- ❑ Difficulties Falling Asleep
- ❑ Difficulties Staying Asleep
- ❑ Waking Unrefreshed
- ❑ Excessive Dreaming or Nightmares

Genitourinary:
- ❑ Blood or Mucus in Urine
- ❑ Frequent Urination
- ❑ Difficulty Controlling Urine
- ❑ Urgency
- ❑ Kidney Stones
- ❑ Bladder Infections
- ❑ Lowered Sex Drive
- ❑ History of Sexually Transmitted Infections

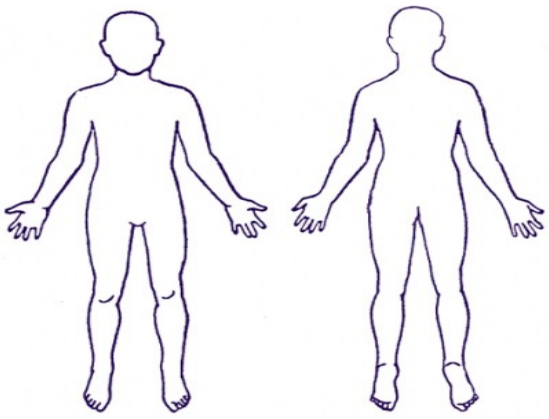
Men's Health:
- ❑ Erectile Difficulties
- ❑ Prostate Difficulties
- ❑ Discharge from the Penis

Women's Health:
- ❑ Bleeding between Periods
- ❑ Clots in Menstrual blood
- ❑ Heavy or Excessive Menstrual Flow
- ❑ Scanty or Light Menstrual Flow
- ❑ Excessive Menstrual Pain or Cramping
- ❑ Irregular Cycles
- ❑ Difficulties Becoming Pregnant
- ❑ Difficulty Maintaining a Pregnancy or History of Miscarriages
- ❑ Menopausal Symptoms

Please list any health concerns not otherwise mentioned: _____

Please Circle any Areas in which you Experience Pain:

Front Back



Consent to Treatment

I attest that the information provided on this form is correct to the best of my knowledge, and I consent to the treatment as I understand it. I understand that I am free to ask questions, and that I may withdraw my consent at any time.

Signature_____ Date_____