PATIENT INTAKE FORM – ADULT

TODAY'S DATE:

NAME: DOB: GENDER: PRONOUNS: ADDRESS: HOME PHONE#: CELL#: EMAIL: EMPLOYER: TEL: EMERGENCY CONTACT NAME: TEL:	**Current Medications/Vitamins/Supplements:** **DRUG/FOOD ALLERGIES & REACTION:**

PHN#

Please ☑ items that apply to you (previously diagnosed or currently experiencing symptoms):

General
- ☐ Allergies
- ☐ Depression
- ☐ Dizziness
- ☐ Fainting
- ☐ Fatigue
- ☐ Fever
- ☐ Headaches
- ☐ Mental Health Trouble
- ☐ Nervousness
- ☐ Sleep Loss
- ☐ Tremors
- ☐ Weight Loss/Gain

Muscle/Joint
- ☐ Arthritis/Rheumatism
- ☐ Bursitis
- ☐ Joint Pain
- ☐ Muscle Weakness
- ☐ Neck Pain
- ☐ Mid Back Pain
- ☐ Low Back Pain
- ☐ Foot Trouble

Skin
- ☐ Boils
- ☐ Bruising Easily
- ☐ Dryness
- ☐ Hives
- ☐ Itching
- ☐ Rash
- ☐ Varicose Veins

Ear, Eye, Nose, & Throat
- ☐ Cough
- ☐ Deafness
- ☐ Ear Ache
- ☐ Eye Pain
- ☐ Gum Problems
- ☐ Hoarseness
- ☐ Nasal Obstruction
- ☐ Nose Bleeds
- ☐ Ringing in Ears
- ☐ Sinus Infection
- ☐ Sore Throat
- ☐ Tonsillitis
- ☐ Vision Problems

Gastrointestinal
- ☐ Abdominal Pain
- ☐ Bloating Abdomen
- ☐ Bloody/Tarry Stool
- ☐ Colitis/Crohn's
- ☐ Colon Trouble
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficult Digestion
- ☐ Diverticulosis
- ☐ Excessive Hunger
- ☐ Gallbladder Trouble
- ☐ Hernia
- ☐ Hemorrhoids
- ☐ Intestinal Infections
- ☐ Jaundice
- ☐ Liver Trouble
- ☐ Nausea
- ☐ Painful Defecation
- ☐ Pain Over Stomach
- ☐ Poor Appetite
- ☐ Vomiting
- ☐ Vomiting of Blood

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder Infection
- ☐ Blood in Urine
- ☐ Kidney Infection
- ☐ Kidney Stones
- ☐ Prostate Trouble
- ☐ Pus in Urine
- ☐ Stress Incontinence

Urinary Habits:
- ☐ Overnight More Than 2x
- ☐ More than 8x in 24 hours
- ☐ Painful Urination
- ☐ Urgency to Urinate

Respiratory
- ☐ Chest Pain
- ☐ Chronic Cough
- ☐ Difficulty Breathing
- ☐ Hay Fever
- ☐ Shortness of Breath
- ☐ Spitting Up Phlegm/Blood
- ☐ Wheezing

Cardiovascular
- ☐ High Blood Pressure
- ☐ Low Blood Pressure
- ☐ Irregular Pulse/Palpitation
- ☐ Pain over Heart
- ☐ Poor Circulation
- ☐ Rapid/Slow Heart Beat
- ☐ Swelling of Ankles

Sexual & Reproductive Health
- ☐ Genital Rash
- ☐ Lumps in Breasts
- Sexually Active in Past 6 Months?
  - ☐ Yes ☐ No
- Last STI/HIV Test Date _____

Menstrual & Vaginal Health (if applies):
- ☐ Hot flashes
- ☐ Menopause
- ☐ Vaginal Discharge
- ☐ Menstrual Pain/Cramps
- ☐ Endometriosis
- ☐ Polycystic Ovary Syndrome (PCOS)
- ☐ Pain with Intercourse
- Menses ☐ Regular ☐ Irregular
- Days of Flow _____
- Length of Cycle _____
- 1st Day of Last Period _____
- Currently Pregnant? ☐ Yes ☐ No
  - If yes, how many months? _____
- Birth Control Method _____
- Last PAP Test Date _____
  - Result: ☐ Normal ☐ Abnormal
- Last Mammogram Date _____
  - Result: ☐ Normal ☐ Abnormal

Penis & Testicular Health (if applies):
- ☐ Decreased Urinary Flow/Force
- ☐ Erectile Dysfunction
- ☐ Premature Ejaculation
- ☐ Painful Ejaculation
- ☐ Scrotal/Testicular Pain
- ☐ Testicular Lump

Check ☑ any of the conditions that apply to you or your blood relatives.
M = Mother
F = Father:
- ☐ Alcoholism
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken Pox
- ☐ Cold Sores
- ☐ Diabetes
- ☐ Eczema
- ☐ Edema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart Burn
- ☐ Heart Disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High Cholesterol
- ☐ HIV/AIDS
- ☐ Hypertension
- ☐ Influenza
- ☐ Malaria
- ☐ Measles
- ☐ Miscarriage
- ☐ Multiple Sclerosis
- ☐ Mumps
- ☐ Numbness/Tingling
- ☐ Pace Maker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic Fever
- ☐ Stroke
- ☐ Thyroid Disease
- ☐ Tuberculosis
- ☐ Ulcers