Adult and Pediatric Intake Form

Name: ______________________ Date of Birth: ______________ Today's Date: ________

Primary Care Physician: ______________________ Height __________ Weight ________

Pharmacy Name: ______________________ Pharmacy Phone number ______________

Reason for visit: ____

Have you had any tests/surgeries for this problem? ______________________________

____

Who referred you to us?

- ☐ Primary care physician
- ☐ Other Physician(s) Name: ______________
- ☐ Non Physician health care provider Name: ______________
- ☐ Phonebook/other Detail: ______________
- ☐ Friend/family

PAST MEDICAL HISTORY (Please Mark all that Apply)

Check if you have a history of: (provide year of diagnosis if known) ☐No Past Medical History

- ☐ADHD _____
- ☐Alcoholism_____
- ☐Allergies_____
- ☐Anemia_____
- ☐Anxiety_____
- ☐Arthritis _____
- ☐Asthma_____
- ☐Blood clots_____
- ☐Bronchitis_____
- ☐Cancer type ________
- ☐Congestive heart failure_____
- ☐COPD_____
- ☐Coronary artery disease or Heart Attack_____
- ☐CVA (Stroke) _______
- ☐Depression_____
- ☐Diabetes Type_____ Insulin/Med_______
- ☐Emphysema_____
- ☐Fibromyalgia_____
- ☐Glaucoma _____
- ☐GERD (Reflux)_____
- ☐Hepatitis A, B, or C _______
- ☐High Cholesterol_____
- ☐HIV_____
- ☐Hypertension_____
- ☐Kidney Disease _____
- ☐Mitral Valve Prolaspe _____
- ☐Pneumonia _____
- ☐Seizures _____
- ☐Sickle Cell _____
- ☐Sleep apnea_____ Check if you use: ☐CPAP/BiPAP
- ☐Systemic lupus erythematosus_____
- ☐Toxic exposures_____
- ☐Hyperthyroid disease_____
- ☐Hypothyroid disease_____
- ☐Tuberculosis_____

Other not listed above:

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____

____

____

Name: ______________________ Date of Birth: ______________ Today's Date: __________

Please list all surgeries or procedures you have had:

☐ No Previous Surgeries

Date	Type of Surgical Procedure	Hospital

Please list all medications including inhalers, herbals and vitamins you are taking:

☐ See List (If You Provided List)

Name	Dose/Strength	How often do you take?

☐ See Additional (Use Additional Sheet if Necessary)

Advance directives in place:

☐ None ☐ DNR ☐ Living Will ☐ Durable Power of Attorney

ALLERGIES

Please list all drug allergies:

Allergic To:	Reaction

FAMILY HISTORY

☐ Check here if family history not available

Diagnosis	Mother	Father	Sister	Brother	Other ___________
	Indicate if Diagnosis was the Cause of Death and at what age.				
Alive and Well	☐____	☐____	☐____	☐____	☐____
Allergies	☐____	☐____	☐____	☐____	☐____
Asthma	☐____	☐____	☐____	☐____	☐____
Cancer, Type___________	☐____	☐____	☐____	☐____	☐____
COPD	☐____	☐____	☐____	☐____	☐____
Heart Disease	☐____	☐____	☐____	☐____	☐____
Diabetes	☐____	☐____	☐____	☐____	☐____
Hearing Loss	☐____	☐____	☐____	☐____	☐____
Bleeding Problems	☐____	☐____	☐____	☐____	☐____
Hypertension	☐____	☐____	☐____	☐____	☐____
Sickle Cell	☐____	☐____	☐____	☐____	☐____
Stroke	☐____	☐____	☐____	☐____	☐____
Sleep Apnea	☐____	☐____	☐____	☐____	☐____
Thyroid Problems	☐____	☐____	☐____	☐____	☐____
Other_________________	☐____	☐____	☐____	☐____	☐____

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REVIEW OF SYSTEMS (Please Mark all that Apply)

Have you experienced any of the following recently:

General	☐ Chills	☐ Fever	☐ Fatigue		
	☐ Activity Changes	☐ Sweating	☐ Weight Loss		
HEENT	☐ Facial Swelling	☐ Neck Pain	☐ Voice Changes	☐ Neck Stiffness	
	☐ Ear Drainage	☐ Nosebleeds	☐ Drooling	☐ Congestion	☐ Mouth Sores
	☐ Runny Nose	☐ Post Nasal Drip	☐ Sneezing	☐ Sinus Pressure	
	☐ Dental Problems	☐ Ringing in Ears	☐ Difficulty Swallowing	☐ Sore Throat	
Respiratory	☐ Apnea	☐ Choking	☐ Shortness of Breath	☐ Chest Tightness	
	☐ Cough	☐ Stridor	☐ Wheezing		
Gastrointestinal	☐ Diarrhea	☐ Constipation	☐ Abdominal Bloating	☐ Blood In Stool	
	☐ Abdominal Pain	☐ Anal Bleeding	☐ Vomiting	☐ Nausea	
	☐ Rectal Pain				
Endocrine	☐ Cold Intolerance	☐ Heat Intolerance	☐ Excessive Thirst		
	☐ Increase Hunger	☐ Increase Urinary Frequency			
Neurological	☐ Dizziness	☐ Facial Asymmetry	☐ Headaches		
	☐ Light-Headedness	☐ Numbness	☐ Seizure		
	☐ Fainting	☐ Tremor	☐ Weakness	☐ Speech Difficulty	
Musculoskeletal	☐ Joint Pain	☐ Back Pain	☐ Balance Problems	☐ Muscle Pain	
	☐ Joint Swelling				
Psychiatric	☐ Agitation	☐ Depression	☐ Hallucinations	☐ Behavior Problem	
	☐ Confusion	☐ Decreased Concentration	☐ Hyperactive	☐ Nervous/Anxious	
	☐ Self-Injury	☐ Sleep Disturbance	☐ Suicidal Ideas		
Skin	☐ Color Change	☐ Unusual Paleness	☐ Rash	☐ Wound	
Allergy/Immun	☐ Environmental Allergies	☐ Food Allergies	☐ Immuno-Compromised		

Tobacco Use? ☐ Never ☐ Current ☐ Previous Date Quit

Type: ____________ Packs per day: ______ Number of years: ____________

Alcohol Use? ☐ Yes ☐ No **Amount:** ____________