Forrest Health Center

- Healing For Body, Mind & Spirit -

ADULT INTAKE

Name: _____ Date: _____

Address: _____

City: _____ State: _____ Zip: _____

Telephone (home): _____ (work): _____

Email address: _____

Age: _____ Date of Birth: _____ Gender: Female / Male

Education: _____

Married:____ Separated:____ Divorced:____ Widowed:____ Single:____ Partnership:_____

Live with: Spouse:____ Partner:____ Parents:____ Children:____ Friends:____ Alone:____

Occupation: _____ Hours per week: _____

Employer Name and Address: _____

_____

How did you hear about this clinic? _____

If internet: Google:____ AANP Website:____ OANP Website:____ Other:_____

Has any other family member already been a patient at this clinic? _____

Emergency contact: _____ Relationship: _____

Phone: _____ Address: _____

_____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

What do you know about our approach?

CONTEXT OF CARE REVIEW

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

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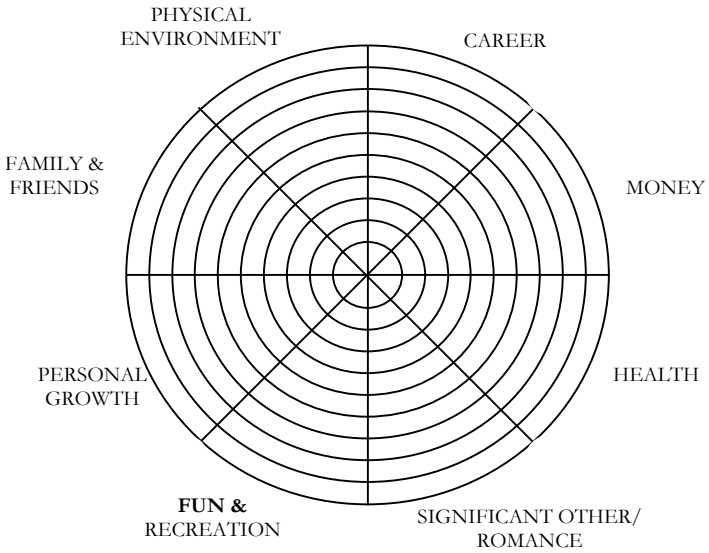
WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.

Do the same for each area, starting from the center point radiating outward.



Are you currently receiving healthcare? Yes / No

If yes, where and from whom? _____

If no, when and where did you last receive medical or health care? _____

_____

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Do you have any known contagious diseases at this time? Yes / No

If yes, what? _____

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FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history? _____
What is your family heritage? _____

CHILDHOOD ILLNESSES

Please circle whether you had any of the following as a child:

Rheumatic fever	Diptheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

_____ year _____ _____ year _____

_____ year _____ _____ year _____

_____ year _____ _____ year _____

ALLERGIES

Are you hypersensitive or allergic to:

Any drugs?

_____

Any foods?

_____

Any environmentals or chemicals?

_____

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CURRENT MEDICATIONS

Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter, vitamins or other supplements:

1) _____ 5) _____

2) _____ 6) _____

3) _____ 7) _____

4) _____ 8) _____

GENERAL

Height: _____ Weight: _____ Weight one year ago: _____

Maximum Weight: _____ When: _____

When during the day is your energy the best? _____ Worst? _____

Main interests and hobbies: _____

Exercise: Y / N If so, what kind and how often: _____

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? ____

Do you have a religious or spiritual practice? Y / N If so, what kind? _____

TYPICAL FOOD INTAKE

Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

To drink:

_____

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FOR THE FOLLOWING, PLEASE CIRCLE:

Y = a condition you have now **N** = never had **P** = a significant problem in the past

GENERAL

Do you sleep well?	Y	N	P
Average 6-8 hours?	Y	N	P
Awake rested?	Y	N	P
Have a supportive relationship?	Y	N	P
Have a history of abuse?	Y	N	P
Experienced a major trauma?	Y	N	P
Use recreational drugs?	Y	N	P
Treated for drug dependence?	Y	N	P
Use alcoholic beverages?	Y	N	P
Use tobacco?	Y	N	P

If in the past, how many years? _____

How many packs per day? _____

Do you enjoy your work?	Y	N	P
Take vacations?	Y	N	P
Spend time outside?	Y	N	P
Eat three meals a day?	Y	N	P
Do you go on diets often?	Y	N	P
Do you eat out often?	Y	N	P
Do you drink coffee?	Y	N	P
Drink black/green tea?	Y	N	P
Drink soda?	Y	N	P
Do you eat refined sugar?	Y	N	P
Do you add salt to your food?	Y	N	P

NEUROLOGIC

Seizures?	Y	N	P
Muscle weakness?	Y	N	P
Loss of memory?	Y	N	P
Vertigo or dizziness?	Y	N	P
Paralysis?	Y	N	P
Numbness or tingling?	Y	N	P
Easily stressed?	Y	N	P
Loss of balance?	Y	N	P

ENDOCRINE

Hypothyroid?	Y	N	P
Hypoglycemia?	Y	N	P
Excessive thirst?	Y	N	P
Fatigue?	Y	N	P

ENDOCRINE CONT.

Heat or cold intolerance?	Y	N	P
Hyperthyroid?	Y	N	P
Diabetes?	Y	N	P
Excessive hunger?	Y	N	P
Seasonal depression?	Y	N	P
Difficulty exercising?	Y	N	P

IMMUNE

Reactions to immunizations?	Y	N	P
Chronically swollen glands?	Y	N	P
Slow wound healing?	Y	N	P
Chronic fatigue syndrome?	Y	N	P
Chronic infections?	Y	N	P
Night sweats?	Y	N	P

EARS

Impaired hearing?	Y	N	P
Ringing in ears?	Y	N	P
Dizziness?	Y	N	P
Ear aches?	Y	N	P

EYES

Impaired vision?	Y	N	P
Cataracts?	Y	N	P
Glaucoma?	Y	N	P
Spots in vision?	Y	N	P
Color blindness?	Y	N	P
Tearing or dryness?	Y	N	P
Eye pain or strain?	Y	N	P

HEAD

Headaches?	Y	N	P
Migraines?	Y	N	P
Head injury?	Y	N	P
Jaw or TMJ problems?	Y	N	P

NOSE AND SINUS

Frequent colds?	Y	N	P
Stuffiness?	Y	N	P

NOSE AND SINUS CONT.

Sinus problems?	Y	N	P
Nose bleeds?	Y	N	P

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Hayfever?	Y	N	P
Loss of smell?	Y	N	P

NECK

Lumps in neck?	Y	N	P
Goiter?	Y	N	P
Difficulty swallowing?	Y	N	P
Pain or stiffness in neck?	Y	N	P

MOUTH AND THROAT

Frequent sore throat?	Y	N	P
Copious saliva?	Y	N	P
Sore tongue or lips?	Y	N	P
Hoarseness?	Y	N	P
Jaw clicks?	Y	N	P
Teeth grinding?	Y	N	P
Gum problems?	Y	N	P
Dental cavities?	Y	N	P

SKIN

Rashes?	Y	N	P
Acne/boils?	Y	N	P
Change in skin color?	Y	N	P
Lumps or bumps on skin?	Y	N	P
Eczema or hives?	Y	N	P
Itching?	Y	N	P
Perpetual hair loss?	Y	N	P

RESPIRATORY

Cough?	Y	N	P
Sputum?	Y	N	P
Asthma?	Y	N	P
Wheezing?	Y	N	P
Bronchitis?	Y	N	P
Coughing up blood?	Y	N	P
Shortness of breath?	Y	N	P
Shortness of breath when lying down?	Y	N	P
Pain in breathing?	Y	N	P

RESPIRATORY CONT.

Emphysema?	Y	N	P
Tuberculosis?	Y	N	P

GASTROINTESTINAL

Trouble swallowing?	Y	N	P
Change in thirst?	Y	N	P
Change in appetite?	Y	N	P
Nausea/vomiting?	Y	N	P
Ulcer?	Y	N	P
Jaundice?	Y	N	P
Gall bladder disease?	Y	N	P
Liver disease?	Y	N	P
Hemorrhoids?	Y	N	P
Pancreatitis?	Y	N	P
Heartburn?	Y	N	P
Abdominal pain or cramps?	Y	N	P
Belching or passing gas?	Y	N	P
Constipation?	Y	N	P
Bowel movements: how often? _____			
Is this a change?_____			
Black stools?	Y	N	P
Blood in stools?	Y	N	P

MENTAL/EMOTIONAL

Treated for emotional problem?	Y	N	P
Depression?	Y	N	P
Anxiety or nervousness?	Y	N	P
Poor concentration?	Y	N	P
Do you have mood swings?	Y	N	P
Considered suicide?	Y	N	P
Attempted suicide?	Y	N	P
Tension?	Y	N	P
Memory problems?	Y	N	P

URINARY

Increased frequency of urination?	Y	N	P
Inability to hold urine?	Y	N	P
Pain in urination?	Y	N	P
Frequency at night?	Y	N	P
Frequent UTI's?	Y	N	P
Kidney stones?	Y	N	P

MUSCULOSKELETAL

Joint pain or stiffness?	Y	N	P
Arthritis?	Y	N	P
Broken bones?	Y	N	P
Weakness?	Y	N	P
Muscle spasms or cramps?	Y	N	P
Sciatica?	Y	N	P

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BLOOD

Anemia? Y N P
Easy bleeding or bruising? Y N P
Cold hands/feet? Y N P
Deep leg pain? Y N P
Thrombophlebitis? Y N P
Varicose veins? Y N P

FEMALE REPRODUCTIVE

Age of first menses:_____
Age of last menses (if menopausal):_____
Length of cycle:_____days
Duration of menses:_____days
Are your cycles regular? Y N P
Painful menses? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
Symptoms:_____
_____
__
Bleeding between cycles? Y N P
Clotting? Y N P
Endometriosis? Y N P
Ovarian cysts? Y N P
Vaginal odor? Y N P
Vaginal discharge? Y N P
Date of last pap smear:_____
Abnormal PAP? Y N P
Cervical dysplasia? Y N P
Are you sexually active? Y N P
Sexual orientation:_____
Birth control? Type:_____
Pain during intercourse? Y N P
Gonorrhea? Y N P
Herpes? Y N P
Chlamydia? Y N P

FEMALE REPRODUCTIVE CONT.

Genital warts? Y N P
Syphilis? Y N P
Difficulty conceiving? Y N P
Number of pregnancies:_____
Number of live births:_____
Number of miscarriages:_____
Number of abortions:_____
Do you do self breast exams? Y N P
Breast pain/tenderness? Y N P
Breast lumps? Y N P
Nipple discharge? Y N P
Menopausal symptoms? Y N P

MALE REPRODUCTIVE

Are you sexually active? Y N P
Sexual orientation:_____
Birth control? Type:_____
Discharge or sores? Y N P
Chlamydia? Y N P
Gonorrhea? Y N P
Genital warts? Y N P
Herpes? Y N P
Syphilis? Y N P
Hernias? Y N P
Testicular masses? Y N P
Testicular pain? Y N P
Prostate disease? Y N P
Impotence? Y N P
Premature ejaculation? Y N P

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