Balanced Family
NATURAL MEDICINE

ADULT INTAKE FORM (13 and older)

Name _____Date of First Visit _____

Address _____

City _____ State _____ Zip Code _____

Telephone (home)_____ (work) _____

(cell)_____ Is it ok to leave a message? _____

Age ____ Date of Birth _____ Social Security Number_____ Gender_____

Single Married Partnership Separated Divorced Widowed

Live with: Spouse Partner Parents Children Friends Alone Roommates

Occupation _____ Hours per week _____ Retired _____

How did you hear about our clinic? _____

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

Emergency Contact _____

Relationship _____ Phone _____

Address _____

Are you currently receiving healthcare? Y N

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) _____

Family History

	Mother	Father	Brothers	Sisters	Maternal GM	Maternal GF	Paternal GM	Paternal GF
Age (if living)								
Health (G=good, P=poor)								
Age at death (if deceased)								
Cause of Death								
Check those Applicable								
Cancer								
Diabetes								
Heart Disease								
High Blood Pressure								
Stroke								
Epilepsy								
Mental Illness								
Asthma/Hayfever/Hives								
Allergies								
Eczema/Psoriasis								
Anemia								
Kidney Disease								
Glaucoma								
Tuberculosis								
Other								

Did you have any of the following childhood illnesses and if so when?

1.) Scarlet Fever_____
2.) Mumps_____
3.) Diphtheria_____
4.) Measles_____
5.) Rheumatic Fever_____
6.) German Measles_____

List Month/Year of following Vaccinations:

1.) Polio_____
2.) Tetanus_____
3.) Measles/Mumps/Rubella_____
4.) Pertussis_____
5.) Diphtheria_____
6.) Hep. B_____
7.) Flu_____
8.) Chicken Pox_____
9.) H. Influenzae (HIB)_____

For all of the following sections:

Y = a condition you have now **N** = never had **P** = a condition you had previously

Musculoskeletal					
Joint pain or stiffness	Y N P	Broken bones	Y N P	Weakness	Y N P
Muscle spasms/cramps	Y N P	Arthritis	Y N P	Sciatica	Y N P
Blood/Peripheral Vasc.					
Easy bleeding/bruising	Y N P	Varicose veins	Y N P	Cold hands/feet	Y N P
Deep leg pain	Y N P	Anemia	Y N P		
Mental/Emotional					
Treated for emotional problems	Y N P	Considered/ Attempted Suicide	Y N P	Anxiety or Nervousness	Y N P
Mood swings	Y N P	Depression	Y N P	Memory problems	Y N P
Poor concentration	Y N P	Tension	Y N P	History of Abuse	Y N
Endocrine					
Hypothyroid	Y N P	Diabetes	Y N P	Heat/Cold intoler.	Y N P
Hyperthyroid	Y N P	Excessive thirst	Y N P	Weight loss/gain	Y N P
Hypoglycemia	Y N P	Fatigue	Y N P	Seasonal Depression	Y N P
Neurologic					
Seizures	Y N P	Paralysis	Y N P	Muscle weakness	Y N P
Numbness or Tingling	Y N P	Loss of memory	Y N P	Easily stressed	Y N P
Vertigo or dizziness	Y N P	Loss of balance	Y N P		
Skin					
Rashes	Y N P	Acne, Boils	Y N P	Hair loss	Y N P
Itching	Y N P	Color Change	Y N P	Night sweats	Y N P
Head					
Headaches	Y N P	Migraines	Y N P	Head Injury	Y N P

Eyes					
Glaucoma	Y N P	Cataracts	Y N P	Impaired vision	Y N P
Glasses or contacts	Y N P	Blurriness	Y N P	Eye pain/strain	Y N P
Color blindness	Y N P	Tearing or dryness	Y N P	Double vision	Y N P
Ears					
Impaired hearing	Y N P	Ringing	Y N P	Earaches	Y N P
Nose and Sinuses					
Frequent colds	Y N P	Nose bleeds	Y N P	Stuffiness	Y N P
Hayfever	Y N P	Sinus problems	Y N P	Loss of smell	Y N P
Mouth and Throat					
Frequent sore throat	Y N P	Copious saliva	Y N P	Teeth grinding	Y N P
Sore tongue/lips	Y N P	Gum problems	Y N P	Hoarseness	Y N P
Dental cavities	Y N P	Jaw clicks	Y N P		
Neck					
Lumps	Y N P	Swollen glands	Y N P	Goiter	Y N P
Pain or stiffness	Y N P				
Respiratory					
Cough	Y N P	Sputum	Y N P	Spitting up blood	Y N P
Wheezing	Y N P	Asthma	Y N P	Bronchitis	Y N P
Shortness of breath	Y N P	Pleurisy	Y N P	Emphysema	Y N P
Tuberculosis	Y N P	Pneumonia	Y N P	Pain with breathing	Y N P
Cardiovascular					
Heart disease	Y N P	Angina	Y N P	Murmurs	Y N P
High/Low blood pressure	Y N P	Blood clots	Y N P	Fainting	Y N P
Palpitations/fluttering	Y N P	Swelling in ankles	Y N P	Chest pain	Y N P
Gastrointestinal					
Trouble swallowing	Y N P	Heartburn	Y N P	Change in thirst	Y N P
Change in appetite	Y N P	Nausea	Y N P	Vomiting	Y N P
Vomiting blood	Y N P	Blood in stool	Y N P	Pain or cramps	Y N P
Belching or passing gas	Y N P	Constipation	Y N P	Diarrhea	Y N P
Gall bladder disease	Y N P	Black stools	Y N P	Ulcer	Y N P
Jaundice (yellow skin)	Y N P	Liver disease	Y N P	Hemorrhoids	Y N P
Bowel movements	how often?			Is this a change?	Y N
Urinary					
Pain on urination	Y N P	Incr. frequency	Y N P	Incontinence	Y N P
Frequency at night	Y N P	Frequent infections	Y N P	Kidney stones	Y N P

Condyloma (genit. warts)	Y N P	Chlamydia	Y N P	Gonorrhea	Y N P
Herpes	Y N P	Syphilis	Y N P		
Male Reproduction					
Testicular masses	Y N P	Hernias	Y N P	Prostate disease	Y N P
Testicular pain	Y N P	Discharge	Y N P	Sores	Y N P
Premature ejaculation	Y N P	Impotence	Y N P		
Are you sexually active?	Y N	Sexual orientation?		Birth control type?	
Female Reprod./Breast					
Age of first menses		Are cycles regular?	Y N	Length of cycle	
Duration of menses		Date of last menses		Clotting	Y N P
Bleeding between cycles	Y N P	Painful menses	Y N P	Light flow	Y N P
Heavy or excessive flow	Y N P	PMS	Y N P		
PMS symptoms?					
Pain during intercourse	Y N P	Endometriosis	Y N P	Ovarian cysts	Y N P
Are you sexually active?	Y N P	Sexual orientation?			
Birth control	Y N P	What type?			
Number of pregnancies		# of Live births		# of miscarriages	
Number of abortions		Abnormal PAP	Y N P	Breast self-exams?	Y N P
Breast pain/tenderness	Y N P	Breast lumps	Y N P	Nipple discharge	Y N P
Breast feeding	Y N P	Mastitis	Y N P		
Menopause	Y N P	Menop. symptoms			

Current Medications					
Laxatives	Y N P	Pain relievers	Y N P	Antacids	Y N P
Cortisone	Y N P	Sleeping Pills	Y N P	Thyroid medications	Y N P

Please list any prescription medications, over the counter medications, vitamins, or supplements you are currently taking:

1)_____ 2)_____
3)_____ 4)_____
5)_____ 6)_____
7)_____ 8)_____

Are you allergic to any medications or other substances? Y N
If yes please explain: _____

What hospitalizations or surgeries have you had? When did they occur?

_____
_____
_____