

### ADULT INTAKE FORM

Name: \_\_\_\_\_ Birthdate \_\_\_\_\_

Home Address: \_\_\_\_\_ H phone \_\_\_\_\_

City, State, Zip: \_\_\_\_\_ W Phone: \_\_\_\_\_

Email \_\_\_\_\_ C Phone \_\_\_\_\_

Sex M F Usual Occupation \_\_\_\_\_ Employer \_\_\_\_\_

Employment status: ` school ` homemaker ` work ` full time  
` part time ` unemployed ` disabled ` retired

Referred by \_\_\_\_\_ Angie's List Member? Yes/No  
Marital status \_\_\_\_\_ Number of children \_\_\_\_\_

Person to be contacted in case of emergency \_\_\_\_\_  
Address \_\_\_\_\_ Phone \_\_\_\_\_

Give the following information for the last times you have been hospitalized starting with the most recent (except normal pregnancies); include type of illness, month and year hospitalized, name of hospital, city and state.

#1: \_\_\_\_\_

#2: \_\_\_\_\_

#3: \_\_\_\_\_

Allergies: \_\_\_\_\_

Medications(Type, Dosage, Frequency) \_\_\_\_\_

Medicinal Herbs, Vitamins, Teas: \_\_\_\_\_

Do you use: ` Coffee: Amount \_\_\_\_\_ ` Cigarettes: Amount \_\_\_\_\_

` Alcohol: Amount \_\_\_\_\_ ` Other drugs: Amount \_\_\_\_\_

Year	Tests
_____	` Chest x-ray
_____	` Electrocardiogram
_____	` TB test
_____	` GI series
_____	` Kidney x-ray
_____	` Barium Enema
_____	` Other x-rays

Year	Immunizations
_____	` Smallpox
_____	` Tetanus
_____	` Polio
_____	` Typhoid
_____	` Mumps, Measles
_____	` Flu
_____	` Other

CHECK for yes only if you have been bothered recently by any of these problems.

Y

- frequent or severe headaches
- back pains
- neck lumps or swelling
- loss of balance
- dizzy spells
- blackouts/fainting
- wear glasses
- blurry vision
- eyesight worsening
- see double
- see halos or lights
- eye pains or itching
- watering eyes
- earaches
- hearing difficulties
- running ears
- noises in ears
- dental problems
- sore or bleeding gums
- sore tongue
- congested nose
- running nose
- sneezing spells
- head colds
  
- nosebleeds
- sore throat
- difficulty swallowing
- hoarse voice
- wheezing or gasping
- frequent coughing
- cough up phlegm
- cough up blood
- chest colds
- rapid or skipped heart beats
- chest pains
- shortness of breath
- swollen feet or ankles
- armpits or groin swelling
- difficulty sleeping
- motion sickness
- excessive sweating

Y

- recurring indigestion
- frequent belching
- nausea
- vomiting
- pain in abdomen
- bloated abdomen
- constipation
- loose bowels
- black stools
- grey or whitish stools
- pain in rectum
- itching rectum
- blood with stools
- frequent urination
- involuntary urination
- burning on urination
- black or bloody urine
- weak urine stream
- diff. starting urine
- constant urge to urinate
- hopeless outlook
- difficulty relaxing
- worry a lot
  
- scary dreams or thoughts
- feeling of desperation
- shy or sensitive
- dislike criticism
- angered easily
- annoyed by little things
- family problems
- problems at work
- sexual difficulties
- change of sexual energy
- considered suicide
- loss or gain in weight
- loss of appetite
- always hungry
- fatigue or weariness
- fever or chills
- motion sickness
- night sweats
- -hot flashes
- warm/colder than others

Y

- aching muscles or joints
- swollen joints
- back or shoulder pains
- weakness in arms or legs
- painful feet
- trembling
- numbness
- leg cramps
- skin problems
- scalp problems
- itching or burning skin
- bruise easily
- nervousness or anxiety
- nervous with strangers
- nail biting
- --diff. making decisions
- lack of concentration
- loss of memory
- lonely or depressed
- frequent crying

**MEN ONLY**

- - burning or discharge
- -swelling on testicles
- - painful testicles

**WOMEN ONLY**

- -missed periods
- -menstrual problems
- -bleeding between periods
- -heavy bleeding
- -bearing down feelings
- -vaginal discharge
- -genital irritation
- -pain on intercourse
- -swelling of breasts
- \_\_\_\_\_#of pregnancies
- \_\_\_\_\_#of births
- \_\_\_\_\_#of miscarriages
- \_\_\_\_\_#of premature births
- \_\_\_\_\_#of caesarean
- \_\_\_\_\_#of abortions

Main Reason for your visit /Additional Comments:

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What are you most sensitive to (eg. noise, odors, light, pain)?\_\_\_\_\_

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Describe an ideal day in terms of weather and temperature: \_\_\_\_\_

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What are your fears?\_\_\_\_\_

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Do you have any hobbies?\_\_\_\_\_

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(Women only) What premenstrual symptoms do you experience?\_\_\_\_\_

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Describe any recurrent dreams, important dreams in your life or recurrent themes in your dreams: \_\_\_\_\_

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How is your energy? Is there any particular time of day when it is lower or higher?\_\_\_\_\_

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What environment do you feel most comfort in? (ie desert, mountains, ocean, city)\_\_\_\_\_

How is your sexual interest/drive?\_\_\_\_\_

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What do you most like to eat or crave?\_\_\_\_\_

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What is your favorite color?\_\_\_\_\_

What foods do you most dislike?\_\_\_\_\_

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How is your thirst?\_\_\_\_\_

What temperature do you like fluids?\_\_\_\_\_

Are there any foods that you are sensitive to or allergic to?\_\_\_\_\_

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