# Sunshine
## Health Care Center

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## ADULT INTAKE FORM

Name: _____ Date: _____

Date of birth: _____ Age: _____ Gender: _____

Address: _____

City: _____ State: _____ Zip: _____

E-mail: _____

Phone: (Home): _____ (Cell/Work): _____

May we leave phone messages relating to your visits? Yes No

Emergency Contact Name: _____ Relationship: _____

Phone: _____ Address: _____

How did you hear about our clinic? _____

Occupation: _____ Hours per week: _____

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

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

Family Physician: _____ Phone: _____

Specialists Involved In Care:

_____ Phone: _____

_____ Phone: _____

What are your main health concerns, in order of importance to:

1. _____

2. _____

3. _____

4. _____

## CONTEXT OF CARE

Successful health care and preventive medicine are only possible when the physician understands the patient physically, mentally and emotionally. Your time, thoughtfulness and honesty in completing this overview will greatly improve our ability to help with your health needs. Feel free to use the back of this form if needed.

Why did you choose to come to this office?

What do you know about our approach?

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 us personally as your health care providers?

What is your present level of commitment to address any underlying causes of your signs and symptoms that may relate to your lifestyle? Rate from 1 to 10, 10 being 100% committed.

1 2 3 4 5 6 7 8 9 10

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

## CONTEXT OF CARE, continued

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

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?

## HEALTH OVERVIEW

Wellness is a balancing of many factors. Please circle your level of overall satisfaction in the following categories, with 10 being the most satisfied and 1 being the least satisfied.

| | | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|---|
| Career / Job | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Family and Friends | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Financial | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Fun / Recreation | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Health Mental | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Health Physical | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Personal Growth / Goals | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Physical Environment | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |
| Romantic Relationship | 1 | 2 | 3 | 4 | 5 | 6 | 7 | 8 | 9 | 10 |

# Sunshine
## Health Care Center

## MEDICAL HISTORY

Current Height: _____ Weight: _____
Maximum Weight: _____ When? _____ Energy level (1-10, 10 highest): _____

Date of last physical exam: _____ Date of last prostate exam (m): _____

Date of last Bone Dexa Scan: _____ Date of last colonoscopy: _____

Date of last mammogram (f): _____ Date of last vision / eye exam: _____

Date of last pap smear (f): _____

Are you hypersensitive or allergic to:

Any drugs? _____ Foods? _____

Environment/Chemicals? _____

How would you describe your general health?
Excellent Good Fair Poor

Other treatments or health care? (e.g. physiotherapy, massage, chiropractic, etc. – please list names, and continue on back if necessary):

_____

_____

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations; along with approximate dates:

_____

_____

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Yes No

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Which medications, either by prescription or over the counter, are you taking or have you taken in the past 6 months? (check all that apply)

| | | | |
|---|---|---|---|
| ☐ Laxatives | ☐ Appetite Suppressants | ☐ Antacids | ☐ Antibiotics |
| ☐ Birth control pills | ☐ Hormone replacement | ☐ Cortisone/Prednisone | ☐ Thyroid medication |
| ☐ Antidepressants | ☐ Sleeping medications | ☐ Anticonvulsants | ☐ Sedatives |
| ☐ Blood pressure meds | ☐ Diuretics | ☐ Cholesterol-lowering medication | |
| ☐ Chemotherapy | ☐ Pain Relievers | ☐ H2 Blockers/Ulcer medication | |

Do you wear any of the following (check all that apply):

☐ Hearing aid(s) ☐ Dentures ☐ Contact Lenses ☐ Prescription Eye Glasses

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## MEDICAL HISTORY, continued

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known.
NOTE: Please bring each of these with you to your first office visit.

1. _____
2. _____
3. _____
4. _____
5. _____

(continue on back if necessary)

Family History: Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known. Check all that apply.

| | | | | |
|---|---|---|---|---|
| ☐ Anemia | ☐ Cancer | ☐ Heart Disease | ☐ Mental Illness | ☐ Alzheimer's |
| ☐ Arthritis | ☐ Diabetes | ☐ Hypertension | ☐ Multiple Sclerosis | ☐ Stroke |
| ☐ Asthma | ☐ Epilepsy | ☐ Kidney Disease | ☐ Parkinson's | ☐ Other (list below) |

Please list other significant family medical history not listed above:

_____

_____

Please list all previous hospitalizations and surgeries (use back if you need more room):

_____

## REVIEW OF SYSTEMS

For the following conditions/symptoms, please circle:
Y = Currently have condition N = Never P = Significant problem in past

| General | | | |
|---|---|---|---|
| Do you sleep well? | Y | N | P |
| Average 6-8 hours? | 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 |
| Drug/alcohol dependence? | Y | N | P |
| Use alcoholic beverages? | Y | N | P |
| Use tobacco? | Y | N | P |
| Do you enjoy your work? | Y | N | P |
| Take vacations? | Y | N | P |
| Spend time outside? | Y | N | P |
| Exercise daily? | Y | N | P |
| Eat three meals a day? | 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 |

# REVIEW OF SYSTEMS, CONT.

For the following conditions/symptoms, please circle:
Y = Currently have condition N = Never P = Significant problem in past

Neurologic, cont.

| | | | |
|---|---|---|---|
| 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 |
| Heat or cold intolerance? | Y | N | P |
| Hyperthyroid? | Y | N | P |
| Diabetes? Excessive hunger? | Y | N | P |
| Seasonal depression? | Y | N | P |
| Difficulty losing weight? | Y | N | P |

Immune

| | | | |
|---|---|---|---|
| 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 |

Head

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

Ears

| | | | |
|---|---|---|---|
| Impaired hearing? | Y | N | P |
| Ringing in ears? | Y | N | P |
| Dizziness? | Y | N | P |
| Earaches? | 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 |

Nose and Sinus

| | | | |
|---|---|---|---|
| Frequent colds? | Y | N | P |
| Stuffiness? | Y | N | P |
| Sinus Problems? | Y | N | P |
| Nose bleeds? | Y | N | P |
| Hayfever? | Y | N | P |
| Loss of smell? | Y | N | P |

Mouth and throat

| | | | |
|---|---|---|---|
| Frequent sore throat? | Y | N | P |
| Copious saliva? | Y | N | P |

Mouth and throat Cont.

| | | | |
|---|---|---|---|
| Sore tongue or lips? | Y | N | P |
| Hoarseness? | Y | N | P |
| Teeth grinding? | Y | N | P |
| Gum problems? | Y | N | P |
| Dental cavities? | 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 |

Skin

| | | | |
|---|---|---|---|
| Rashes? | Y | N | P |
| Acne/boils? | Y | N | P |
| Change in skin color? | Y | N | P |
| Skin lumps or bumps? | 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 |
| Painful breathing? | Y | N | P |
| Emphysema? | Y | N | P |
| Tuberculosis? | Y | N | P |
| Shortness of breath lying down? | 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, cramps? | Y | N | P |
| Belching or passing gas? | Y | N | P |
| Constipation? | Y | N | P |
| Bowel movements: how often? _____ | | | |
| Is this a change? | Y | N | |
| Black stools? | Y | N | P |
| Blood in stools? | Y | N | P |

# REVIEW OF SYSTEMS, CONT.

For the following conditions/symptoms, please circle:
Y = Currently have condition N = Never P = Significant problem in past

Mental Emotional

| | | | |
|---|---|---|---|
| Treated for emotional problems? | Y | N | P |
| Depression? | Y | N | P |
| Anxiety or nervousness? | Y | N | P |
| Poor concentration? | Y | N | P |
| Mood swings? | Y | N | P |
| Considered 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 urinary infections? | 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 |

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 |

Cardiovascular

| | | | |
|---|---|---|---|
| Palpitations: | Y | N | P |
| Chest Pain: | Y | N | P |
| Murmurs: | Y | N | P |
| Heart Attack: | Y | N | P |
| Rheumatic Fever: | Y | N | P |
| Edema: | Y | N | P |
| High Blood Pressure: | Y | N | P |
| Arrhythmias: | Y | N | P |
| Low Blood Pressure: | Y | N | P |

Female Reproductive, cont.

| | | | |
|---|---|---|---|
| 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 |
| Are you sexually active? | Y | N | P |
| If yes, with men, women or both? | | | |
| Birth control? | Y | N | P |
| Type(s):_____ | | | |
| STD prevention? | Y | N | P |
| Type(s):_____ | | | |
| Pain during intercourse? | Y | N | P |
| Sexually transmitted infections? | 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 |
| If yes, with men, women or both? | | | |
| Birth control? | Y | N | P |
| Type(s):_____ | | | |
| STD prevention? | Y | N | P |
| Type(s):_____ | | | |
| Discharge or sores? | Y | N | P |
| Sexually transmitted infections? | Y | N | P |
| Testicular masses? | Y | N | P |
| Testicular pain? | Y | N | P |
| Do you do self testicular exams? | Y | N | P |
| Prostate disease? | Y | N | P |
| Erectile dysfunction? | Y | N | P |
| Premature ejaculation? | Y | N | P |