NAPA NATURAL MEDICINE

Adult Intake Form

Name _____ Age _____

Date of Birth _____ Gender _____

Height _____ Weight _____

Contact Information

Address _____

(Street) (City) (Zip Code)

Phone Number _____

(Home) (Mobile) (Work)

Email Address _____

What is the best way to reach you?

_____

How did you hear about us?

_____

Personal Health Information

(Please use additional pages or the back of this form as needed to complete health information)

What are your chief health concerns?

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

If you are a female, are you currently pregnant? Yes No (Please circle one)

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

Are you currently taking any prescription medication? (If yes please list name, amount, reason for use, length of use and name of prescriber)

1. _____
2. _____
3. _____

Are you currently taking any vitamins, minerals, supplements, herbal or homeopathic medicines? (If yes please list name, amount, reason for use, length of use and name of prescriber)

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

Do you have any allergies? (If yes, please list)

_____
_____
_____

Do you use any of the following? (Please circle)

Aspirin / Antacids / Birth Control pill / Diet pills/Sleeping pills

Alcohol (frequency, amount, and form): _____

Tobacco (frequency, quantity): _____

Caffeine (quantity): _____

Recreational drugs (type, frequency): _____

How many times have you been treated with antibiotics? (for what purpose and when)

_____
_____

Do you get regular check-ups from another doctor? Yes No (Please circle one)

Have you had any of the following health conditions in the past or do you currently have any of the following conditions?

Condition	Have it currently	Had it in the past (list when)	Condition	Have it currently	Had it in the past (list when)
Asthma			Arthritis		
Auto immune disease			Addiction		
Cancer			Diabetes		
Heart Disease			Hypertension		
Insomnia			Mental Health Concern		
Eating Disorder			Vascular problems		

Have you been hospitalized or seriously injured in the past? (If yes, list event that occurred and dates)

Hospitalization or Injury	Date(s)	Hospitalization or Injury	Date(s)

Which of the following vaccines have you received and when have you received them?

Vaccination	Date(s) Received	Vaccination	Date(s) Received
MMR (Measles, Mumps, Rubella)		Hepatitis	
DPT (Diphtheria, Pertussis, Tetanus)		Haemophilis Influenza	
Polio		Meningitis	
Influenza		Other	

Dietary Information

Do you have any food allergies or intolerances not listed above? (If yes, please list)

_____

What do you eat and drink on a typical day? (Include beverages)

Morning: _____

Afternoon: _____

Evening/Night: _____

Beverages: _____

How is your digestion in general? Do you experience gas, bloating, indigestion, heartburn, diarrhea, or constipation?

_____

_____

Family Health Information

Has anyone in your family had any of the following health concerns?

Health Concern	Family Member	Health Concern	Family Member
Diabetes		High Blood Pressure	
Cancer		Alcoholism	
Heart Disease		Mental health concerns	

Do your children, partner/spouse, siblings, parents, or other family members have any health concerns not listed above? (If yes, please list)

Environment

What is your occupation?

_____

What are your hobbies?

_____

Are you exposed to smoke frequently?

_____

Are you exposed to any environmental toxins that you know of?

_____

How is your sleep in general? Do you have difficulty falling or staying asleep?

_____

_____

Do you exercise? How often and what type?

_____

Health Care Provider Information

_____ _____

(Name) (Name)

_____ _____

(Address) (Address)

_____ _____

(Phone) (Fax) (Phone) (Fax)

Can we contact your other healthcare providers concerning your care? Yes No