



# Family Health Clinic

## ADULT INTAKE FORM

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ Sex M F

Address  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Phone  
(h) \_\_\_\_\_  
(w) \_\_\_\_\_  
(other) \_\_\_\_\_

May we leave messages  
relating to your visits?  
Y N

Emergency contact: Name \_\_\_\_\_ Phone \_\_\_\_\_

Referred by \_\_\_\_\_

Other health care providers

- |               |               |               |
|---------------|---------------|---------------|
| 1. _____      | 2. _____      | 3. _____      |
| _____         | _____         | _____         |
| _____         | _____         | _____         |
| (_____) _____ | (_____) _____ | (_____) _____ |

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

1. \_\_\_\_\_  
\_\_\_\_\_
2. \_\_\_\_\_  
\_\_\_\_\_
3. \_\_\_\_\_  
\_\_\_\_\_
4. \_\_\_\_\_  
\_\_\_\_\_
5. \_\_\_\_\_  
\_\_\_\_\_

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

**Medical history**

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

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

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Do you have any allergies (medicines, environmental, etc.)?

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Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

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Please list past prescription medications.

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How many times have you been treated with antibiotics? \_\_\_\_\_

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

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol—how much/day or week \_\_\_\_\_

Tobacco—form and amount/day \_\_\_\_\_

Caffeine—form and amount/day \_\_\_\_\_

Recreational drugs—what and how often \_\_\_\_\_

Please indicate what immunizations you have had

- |   |  |                                      |
|---|--|--------------------------------------|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) | <input type="checkbox"/> Haemophilus influenza B | <input type="checkbox"/> Hepatitis A |
| <input type="checkbox"/> Tetanus booster; when? _____         | <input type="checkbox"/> "Flu"                   | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> MMR (measles, mumps, rubella)        | <input type="checkbox"/> Polio                   | <input type="checkbox"/> Smallpox    |
- Other \_\_\_\_\_

Please indicate if any caused adverse reactions

\_\_\_\_\_

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

**Diet**

Do you have any food allergies or intolerances? Please list.

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

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

\_\_\_\_\_  
 \_\_\_\_\_

Describe a typical day's diet

Breakfast \_\_\_\_\_  
 Lunch \_\_\_\_\_  
 Dinner \_\_\_\_\_  
 Snacks \_\_\_\_\_  
 Beverages (and total quantity) \_\_\_\_\_

**Family history**

Indicate if a close relative (parent, child, sibling) has had any of the following

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

**Environment**

Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

\_\_\_\_\_  
\_\_\_\_\_

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home

heated? \_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Environment (cont'd)**

How would you describe the emotional climate of your home?

\_\_\_\_\_  
\_\_\_\_\_

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Is there anything that you feel is important that has not been covered?

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_