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# ADULT INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person **3 business days** before your appointment.
*To enter information, click on the gray box. Press "tab" or manually "click" to move to the next gray box. Save answers.*

**PROFILE:**

Name: _____ Gender: ☐ M ☐ F Age: _____

Today's Date: _____/_____/_____ (mm/dd/yyyy) Date of Birth: _____/_____/_____ (mm/dd/yyyy)

Address: _____

Telephone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

Prefer Email Correspondence? ☐ Y ☐ N Email: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Children / Ages: _____

How did you hear about us? _____

May we give you appointment reminder calls? ☐ Y ☐ N (phone) _____-_____-_____

May we leave you phone messages? ☐ Y ☐ N (phone) _____-_____-_____ ☐ same as above

**EMERGENCY CONTACT:**

Name: _____ Relationship: _____

Telephone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

**MEDICAL CONTACTS:**

Name of Medical Doctor / Family Physician:

Telephone: _____-_____-_____

Date of last blood work: Date of last annual / physical exam:

List any other health care providers (name, specialty, telephone):

**MEDICAL HISTORY:**

List your health concerns in order of importance to you:

**1.** _____

**2.** _____

**3.** _____

**4.** _____

**5.** _____

Has any health concern recently changed or become worse? ☐ Y ☐ N

_____

What has your doctor (currently & previously) diagnosed you with?

_____

_____

_____

_____

_____

_____

_____

Please list all current medications (prescription or over-the-counter) and supplements (herbs, vitamins)

| Name of Drug / Supplement | Used For | Date Started | Dose / Frequency |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

List past prescription medications: _____

_____

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

_____

_____

_____

_____

_____

_____

_____

Present Weight: _____ Weight one year ago: _____

Maximum weight and when: _____ Minimum weight (adult) and when: _____

Ideal weight: _____ Height: _____

Which of the following do you currently use?

| Y = Current | N = Never | P = Past |
|---|---|---|

| Substance | Y | P | N | Per day | Type | Duration |
|---|---|---|---|---|---|---|
| Coffee | ☐ | ☐ | ☐ | | | |
| Soft Drinks (sodas) | ☐ | ☐ | ☐ | | | |
| Artificial Sweeteners | ☐ | ☐ | ☐ | | | |
| Tobacco | ☐ | ☐ | ☐ | | | |
| Alcohol | ☐ | ☐ | ☐ | | | |
| Recreational Drugs | ☐ | ☐ | ☐ | | | |
| Painkillers | ☐ | ☐ | ☐ | | | |
| Steroids | ☐ | ☐ | ☐ | | | |
| Laxatives | ☐ | ☐ | ☐ | | | |
| Analgesics | ☐ | ☐ | ☐ | | | |
| Antacids | ☐ | ☐ | ☐ | | | |

List any traumas (mental, emotional, physical), injury, illness, surgery or hospitalizations:

| Incident | Date | Long-term effects |
|---|---|---|
| | | |
| | | |
| | | |

Note when and why you have had each of the following:

| | | | |
|---|---|---|---|
| **X-Rays:** | | **MRI:** | |
| **Ultrasounds:** | | **CAT Scans:** | |
| **Tuberculosis Test:** | | **Last Dental Work:** | |
| **HIV test:** | | **Last Eye Exam:** | |

**FOR MALES (*if applicable*):**

| |
|---|
| Are you currently sexually active? ☐ Y ☐ N Have you been sexually active in the past? ☐ Y ☐ N |
| Do you use forms of contraception? ☐ Y ☐ N ☐ Sometimes Since: |
| Do you have regular prostate exams? ☐ Y ☐ N |
| Do you have difficulty urinating completely? ☐ Y ☐ N |
| How many times do you get up from your sleep to go to the bathroom at night? |
| Do you have any sexual problems or concerns? ☐ Y ☐ N Explain: |

**FOR FEMALES (*if applicable*):**

| |
|---|
| Are you pregnant? ☐ Y ☐ N ☐ Unknown Age at first period: |
| Date of last menstrual period: Length of monthly cycle (days): Length of bleeding (days): |
| Are you currently sexually active? ☐ Y ☐ N Have you been sexually active in the past? ☐ Y ☐ N |
| Do you use birth control? ☐ Y ☐ N ☐ Sometimes |
| Method: Since: |

Number of pregnancies: Live births: Miscarriages: Abortions:

Date of last PAP test: Any irregular PAP test? ☐ Y ☐ N

Dexa (bone density) Scan results: _____

Mammography? ☐ Y ☐ N Results? _____ Do you perform self-breast exams monthly? ☐ Y ☐ N

Have you had any of the following concerning your breasts?

☐ Pain ☐ Lumps ☐ Infections ☐ Cysts ☐ Nipple discharge ☐ Other _____

_____

Do you experience PMS? ☐ Y ☐ N

If yes, what are your symptoms of PMS?

☐ Cravings ☐ Bloating ☐ Breast tenderness ☐ Mood changes ☐ Other: _____

_____

Are you menopausal? ☐ Y ☐ N Age of last period:

If yes, list any menopausal symptoms: _____

Use of hormones? ☐ Y ☐ N

Type and dosage of hormones: _____

Do you experience vaginal infections? ☐ Never ☐ Rarely ☐ Frequently

Do you experience bladder infections? ☐ Never ☐ Rarely ☐ Frequently

Do you have any sexual problems or concerns? ☐ Y ☐ N Explain:

**CHILDHOOD ILLNESSES:** (*check all that apply*)

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Rheumatic fever

☐ Scarlet fever ☐ Tuberculosis ☐ Pertussis ☐ Other: _____

Where are you in the birth order? ☐ First ☐ Last ☐ Middle ☐ Only

**VACCINATIONS:** (*check all that apply*)

☐ DPT (diptheria, pertussis, tetanus) ☐ HIB (haemophilus influenza B) ☐ Small pox ☐ Varicella (chicken pox)

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Gardasil (HPV) ☐ Hepatitis A

☐ Hepatitis B ☐ Seasonal Flu shot ☐ Tetanus Booster ☐ RotaVirus

☐ Meningococcal ☐ Pneumococcal ☐ Unknown

Adverse reactions to any vaccines: ☐ Y ☐ N / If so, please explain _____

How many times have you been treated with antibiotics? For what condition(s)?_____

_____

_____

Have you ever used probiotics after antibiotic use? ☐ Y ☐ N

**FAMILY HISTORY:**

Please indicate if you or any of your immediate family has had any of the following conditions:

| Condition | Family Member(s) | Condition | Family Member(s) |
|---|---|---|---|
| Alcoholism / Drug abuse | | Epilepsy | |
| Allergies / Hayfever | | Heart disease | |
| Arthritis | | High blood pressure | |
| Asthma / Emphysema | | Kidney disease | |
| Auto-immune disease | | Liver disease | |
| Bleeding disorder | | Mental illness | |
| Cancer | | Overweight / Obesity | |
| Diabetes | | Stroke | |
| Digestive disorder | | Thyroid problems | |
| Eating disorder | | Other: | |

☐ I don't know my family medical history (please explain why) _____

_____

**DIET / DIGESTION / LIFESTYLE / ENVIRONMENTAL:**

Please record your diet for the last 3 days:

| | Day 1 | Day 2 | Day 3 |
|---|---|---|---|
| **Breakfast** | | | |

| | | | |
|---|---|---|---|
| | | | |
| **Lunch** | | | |
| **Dinner** | | | |

Do you have dietary restrictions (religious, vegetarian, vegan)? ☐ Y ☐ N _____

How much water in ***ounces*** do you drink per day? _____ Type of water: _____

How much coffee do you drink per day? _____

How often do you have a bowel movement? _____

Do you tends towards? ☐ Constipation ☐ Diarrhea ☐ Both ☐ Other: _____

What is the color of your stool? _____ Any undigested food in stool? ☐ Y ☐ N

What is the shape of your stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other: _____

| **Y = Current** | **N = Never** | **P = Past** |
|---|---|---|

Good energy? ☐ Y ☐ N Rate your energy level: /10 (10 = best)

Fatigue: ☐ Y ☐ N ☐ P

If you have fatigue, when in morning, afternoon, evening is it the worst? _____

If you have fatigue, can you do what you need to during the day? ☐ Y ☐ N

Rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

Outlets to relieve stress: _____

_____

How often do you exercise? _____

What type of exercise? _____ For how long? _____

How many hours of sleep per night? _____ If waking up frequently, what is the reason? _____

Nightmares? ☐ Y ☐ N ☐ P Sleepwalk? ☐ Y ☐ N ☐ P

Wake Refreshed? ☐ Y ☐ N ☐ P Must nap during the day? ☐ Y ☐ N ☐ P

Grind teeth? ☐ Y ☐ N ☐ P Snore? ☐ Y ☐ N ☐ P

Enjoy job? ☐ Y ☐ N ☐ P Hours worked per week? _____

Highest education level: _____

Quality of significant relationship: _____

How do you spend your free time? _____

History of sexual, mental/emotional, physical abuse? ☐ Y ☐ N

If so, at what age and by whom? _____

Active spiritual practice? ☐ Y ☐ N ☐ P

Spiritually satisfied? ☐ Y ☐ N ☐ P ☐ Not sure _____

If not active spiritually or spiritually satisfied, do you desire to explore and discover this area of health? ☐ Y ☐ N

What is your greatest health concern? _____

How does it limit you the most? _____

How committed are you towards making valuable changes? ☐ Little ☐ Moderate ☐ Very ☐ Don't Know

**REVIEW OF SYMPTOMS:**

| Y = Current | N = Never | P = Past |
|---|---|---|

| SKIN | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Rash: | ☐ Y | ☐ N | ☐ P | | Color change: | ☐ Y | ☐ N | ☐ P |
| Hives: | ☐ Y | ☐ N | ☐ P | | Lump: | ☐ Y | ☐ N | ☐ P |
| Psoriasis / eczema | ☐ Y | ☐ N | ☐ P | | Itchy: | ☐ Y | ☐ N | ☐ P |
| Dry: | ☐ Y | ☐ N | ☐ P | | Warts / moles: | ☐ Y | ☐ N | ☐ P |
| Cancer: | ☐ Y | ☐ N | ☐ P | | Perspiration | ☐ Y | ☐ N | ☐ P |
| **HEAD** | | | | | | | | |
| Headache: | ☐ Y | ☐ N | ☐ P | | Migraine: | ☐ Y | ☐ N | ☐ P |
| Dandruff: | ☐ Y | ☐ N | ☐ P | | Head injury: | ☐ Y | ☐ N | ☐ P |
| Oily / dry hair: | ☐ Y | ☐ N | ☐ P | | Hair loss: | ☐ Y | ☐ N | ☐ P |

| NOSE | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Frequent Colds: | ☐ Y | ☐ N | ☐ P | | Nosebleeds: | ☐ Y | ☐ N | ☐ P |
| Congestion: | ☐ Y | ☐ N | ☐ P | | Post nasal drip: | ☐ Y | ☐ N | ☐ P |
| Polyps: | ☐ Y | ☐ N | ☐ P | | Seasonal Allergies: | ☐ Y | ☐ N | ☐ P |
| **EYES** | | | | | | | | |
| Dry / Watery: | ☐ Y | ☐ N | ☐ P | | Blurry Vision: | ☐ Y | ☐ N | ☐ P |
| Double Vision: | ☐ Y | ☐ N | ☐ P | | Cataracts: | ☐ Y | ☐ N | ☐ P |
| Glaucoma: | ☐ Y | ☐ N | ☐ P | | Styes: | ☐ Y | ☐ N | ☐ P |
| Strain: | ☐ Y | ☐ N | ☐ P | | Discharge: | ☐ Y | ☐ N | ☐ P |
| Itchy: | ☐ Y | ☐ N | ☐ P | | Dark under eyelid | ☐ Y | ☐ N | ☐ P |
| **MOUTH / THROAT** | | | | | | | | |
| Canker sores: | ☐ Y | ☐ N | ☐ P | | Cold sores: | ☐ Y | ☐ N | ☐ P |
| Sore throat: | ☐ Y | ☐ N | ☐ P | | Gum disease: | ☐ Y | ☐ N | ☐ P |
| Dentures: | ☐ Y | ☐ N | ☐ P | | Cavities: | ☐ Y | ☐ N | ☐ P |
| Loss of tastes: | ☐ Y | ☐ N | ☐ P | | Hoarsness: | ☐ Y | ☐ N | ☐ P |
| **NECK** | | | | | | | | |
| Stiffness: | ☐ Y | ☐ N | ☐ P | | Swollen glands: | ☐ Y | ☐ N | ☐ P |
| Full movement: | ☐ Y | ☐ N | ☐ P | | Tension: | ☐ Y | ☐ N | ☐ P |
| **RESPIRATORY** | | | | | | | | |
| Cough: | ☐ Y | ☐ N | ☐ P | | Tuberculosis | ☐ Y | ☐ N | ☐ P |
| Shortness of breath w/ exertion: | ☐ Y | ☐ N | ☐ P | | Bronchitis | ☐ Y | ☐ N | ☐ P |
| Shortness of breath sitting: | ☐ Y | ☐ N | ☐ P | | Pneumonia: | ☐ Y | ☐ N | ☐ P |
| Shortness of breath lying down: | ☐ Y | ☐ N | ☐ P | | Asthma | ☐ Y | ☐ N | ☐ P |
| Wheezing: | ☐ Y | ☐ N | ☐ P | | Painful breathing | ☐ Y | ☐ N | ☐ P |

| CARDIOVASCULAR | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| High Blood Pressure: | ☐ Y | ☐ N | ☐ P | | Rheumatic Fever | ☐ Y | ☐ N | ☐ P |
| Low Blood Pressure: | ☐ Y | ☐ N | ☐ P | | Murmurs | ☐ Y | ☐ N | ☐ P |
| Arrhythmias: | ☐ Y | ☐ N | ☐ P | | Palpitations: | ☐ Y | ☐ N | ☐ P |
| Edema: | ☐ Y | ☐ N | ☐ P | | Chest pain: | ☐ Y | ☐ N | ☐ P |
| **URINARY TRACT** | | | | | | | | |
| Incontinence: | ☐ Y | ☐ N | ☐ P | | Pain w/ urination | ☐ Y | ☐ N | ☐ P |
| Frequent Infections: | ☐ Y | ☐ N | ☐ P | | Kidney Stones | ☐ Y | ☐ N | ☐ P |
| Urgency | ☐ Y | ☐ N | ☐ P | | Discharge / blood | ☐ Y | ☐ N | ☐ P |
| **GASTROINTESTINAL** | | | | | | | | |
| Heartburn: | ☐ Y | ☐ N | ☐ P | | Parasites | ☐ Y | ☐ N | ☐ P |
| Indigestion: | ☐ Y | ☐ N | ☐ P | | Blood in stool | ☐ Y | ☐ N | ☐ P |
| Bloating: | ☐ Y | ☐ N | ☐ P | | Diarrhea | ☐ Y | ☐ N | ☐ P |
| Nausea: | ☐ Y | ☐ N | ☐ P | | Constipation | ☐ Y | ☐ N | ☐ P |
| Vomiting: | ☐ Y | ☐ N | ☐ P | | Liver disease: | ☐ Y | ☐ N | ☐ P |
| Change in appetite: | ☐ Y | ☐ N | ☐ P | | Gall bladder disease | ☐ Y | ☐ N | ☐ P |
| Pancreatitis: | ☐ Y | ☐ N | ☐ P | | Ulcer | ☐ Y | ☐ N | ☐ P |
| **MUSCULOSKELETAL** | | | | | | | | |
| Weakness: | ☐ Y | ☐ N | ☐ P | | Arthritis: | ☐ Y | ☐ N | ☐ P |
| Stiffness: | ☐ Y | ☐ N | ☐ P | | Leg cramps: | ☐ Y | ☐ N | ☐ P |
| Tremors: | ☐ Y | ☐ N | ☐ P | | Pain: | ☐ Y | ☐ N | ☐ P |
| **NERVOUS SYSTEM** | | | | | | | | |
| Paralysis: | ☐ Y | ☐ N | ☐ P | | Sciatica: | ☐ Y | ☐ N | ☐ P |
| Tingling / numbness: | ☐ Y | ☐ N | ☐ P | | Carpal tunnel: | ☐ Y | ☐ N | ☐ P |

| | | | | | | | | |
|---|---|---|---|---|---|---|---|---|
| Seizures: | ☐ Y | ☐ N | ☐ P | | Fainting: | ☐ Y | ☐ N | ☐ P |
| **MENTAL / EMOTIONAL** | | | | | | | | |
| Depression: | ☐ Y | ☐ N | ☐ P | | Anger / Irritability | ☐ Y | ☐ N | ☐ P |
| Suicidal: | ☐ Y | ☐ N | ☐ P | | High strung/ tense | ☐ Y | ☐ N | ☐ P |
| Anxiety | ☐ Y | ☐ N | ☐ P | | Fear / Panic: | ☐ Y | ☐ N | ☐ P |
| Eating disorder: | ☐ Y | ☐ N | ☐ P | | Psych hospitalization | ☐ Y | ☐ N | ☐ P |
| PTSD | ☐ Y | ☐ N | ☐ P | | Brain Fog | ☐ Y | ☐ N | ☐ P |
| **MISCELLANEOUS** | | | | | | | | |
| Night Sweats: | ☐ Y | ☐ N | ☐ P | | Cold hands / feet | ☐ Y | ☐ N | ☐ P |
| Spontaneous sweat | ☐ Y | ☐ N | ☐ P | | Phlegm | ☐ Y | ☐ N | ☐ P |
| Easily awaken | ☐ Y | ☐ N | ☐ P | | Loss of voice | ☐ Y | ☐ N | ☐ P |
| Foul breath | ☐ Y | ☐ N | ☐ P | | Thirsty | ☐ Y | ☐ N | ☐ P |
| Bruise easily | ☐ Y | ☐ N | ☐ P | | Hemorrhoids | ☐ Y | ☐ N | ☐ P |
| Excessive dreaming | ☐ Y | ☐ N | ☐ P | | Bitter tasting mouth | ☐ Y | ☐ N | ☐ P |
| Brittle nail | ☐ Y | ☐ N | ☐ P | | Oversleep | ☐ Y | ☐ N | ☐ P |
| Sigh easily | ☐ Y | ☐ N | ☐ P | | Ringing ears | ☐ Y | ☐ N | ☐ P |

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health, and in adhering to the therapeutic protocols? _____

_____

What are your goals and expectations after your first new patient visit with Dr. Walter? _____

_____

Is there any other information that you feel is important that has not been covered? _____

_____

**Thank you very much for taking the time to complete this thorough form.**
**It will greatly assist in the formulation of an individualized plan specific to your healthcare needs.**