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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.