northshore Family Practice

ADULT INTAKE

NAME: ____ **DOB:**________________________

Context of Care

What *three* expectations do you have from *this* visit to our clinic?

1.
2.
3.

What *long-term* expectations do you have from working with our clinic?

What is your present level of commitment to addressing any underlying issues that relate to your lifestyle?

Rate from 0 to 10 - 10 being 100% committed

0% 1 2 3 4 5 6 7 8 9 100%

HEALTH & LIFESTYLE

Age: _____________ Marital Status: ☐ single ☐ married/partnered ☐ divorced ☐ widowed # of Children: ________

Have you had *unintentional* weight gain or loss of 10 or more pounds in the last month? ☐ Yes ☐ No

Are you pregnant? ☐ Yes ☐ No Are you breastfeeding? ☐ Yes ☐ No Drug Allergies: ☐ Yes ☐ No

Please list any allergies: ____

Do you have: ☐ Corrective Lenses ☐ Dentures ☐ Hearing Aid ☐ Other Medical Device ____________________

Occupation: ____ Hours worked per week: ______________

Main interests and hobbies: ____

Exercise: ☐ Yes ☐ No If so, what kind and how often: _______________________________________

Watch TV: ☐ Yes ☐ No If so, how many hours? ____

Read: ☐ Yes ☐ No If so, how many hours? ____

Do you have a religious or spiritual practice? ☐ Yes ☐ No If so, what kind? _________________________

HEALTHCARE STATUS

Are you currently receiving healthcare? ☐ Yes ☐ No

If yes, where and from whom? ____

____

If no, when and where did you last receive medical or health care? ________________________

____

For what reason were you seen? ____

____

Have you had any recent labwork done (within last 6mo)? ☐ Yes ☐ No

If so, where? ____

What are your most important health issues right now? List as many as you can in order of importance.

- ____
- ____
- ____
- ____
- ____
- ____
- ____

What types of therapies have you tried for these problems? *Put a * next those that have helped*

☐ Diet Modification ☐ Fasting ☐ Vitamins/Minerals ☐ Herbs ☐ Homeopathy

☐ Chiropractic ☐ Acupuncture ☐ Conventional Rx ☐ Other: ____________________

Do you have any known contagious diseases at this time? ☐ Yes ☐ No

If yes, what? ____

Past Serious Illness/Infections

Illness:______________________ Year:_____ Illness:______________________ Year:_____

Illness:______________________ Year:_____ Illness:______________________ Year:_____

Illness:______________________ Year:_____ Illness:______________________ Year:_____

HOSPITALIZATIONS, SURGERY & IMAGING

What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

Procedure:__________________Year:______ Procedure:__________________Year:______

Procedure:__________________Year:______ Procedure:__________________Year:______

Procedure:__________________Year:______ Procedure:__________________Year:______

FAMILY HISTORY

Do you or anyone in your family have a history of any of the following? (*please check and write who*)

□ Cancer	□ Diabetes	□ Heart Disease	□ High Blood Pressure
□ Kidney disease	□ Epilepsy	□ Arthritis	□ Glaucoma
□ Tuberculosis	□ Stroke	□ Anemia	□ Mental Illness
□ Asthma	□ Hay fever	□ Hives	□ Depression or Suicide
□ Eating Disorder	□ Genetic Disorder	□ Dementia	□ Alcoholism / Addiction
□ Learning Disabilities	□ Osteoporosis	□ Migraines	□ Obesity
□ Parkinson's	□ Multiple Sclerosis	□ Alzheimer's	□ Other: ____________________

Other relevant family history? ____

What is your family heritage? ____

CHILDHOOD ILLNESSNESS

Birth location: ____________________________ Time: ______________________ Weight: _________________

Please mark any diseases you had as a child:

□ Rheumatic Fever	□ Scarlet Fever	□ German Measles	□ Mumps
□ Diptheria	□ Chicken Pox	□ Measles	□ Other:

CURRENT MEDICATIONS

Please list any other prescription medications, over the counter medications, vitamins or other supplements you are taking, *including the dosage*:

- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________
- _____________________________________