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Intake Form - Adult

Full Name: _____		Today's Date: _____
Age: _____	Birth Date: _____	Male or Female (Circle One)
Address: _____		City/State: _____
Zip: _____	Phone: _____	Email: _____
Occupation: _____	Emergency Contact Number: _____	
Emergency Contact Name: _____		Relationship to You: _____
Marital Status (Circle One) Single Married Separated Divorced Widowed		

Please check all applicable options and add comments as needed

I. Questions Regarding Overall Health:

Date of last physical: _____

Do you suffer from any of the following?

A. Sleep

- Difficulty Falling Asleep or Staying Asleep
- Difficulty Waking
- Restless Sleep
- Sleepwalking/Night terrors/Nightmares
- Bruxism (Grinding teeth)

B. Auditory/Olfactory

- Ringing in the Ears
- Hearing Loss
- Ear aches
- Decrease in Sense of Smell

C. Visual

- Double Vision
- Vision Problems/Blurred Vision
- Blind Spots

Clinician's Notes

Onset:

Duration:

Length:

Quality:

Dreams:

D. Other

- Allergies
- Asthma
- Frequent illness
- Fatigue
- Chronic pain

Clinician's Notes

E. Cardiovascular / Pulmonary

Heart Problems Breathing Problems Palpitations or Tachycardia Hypertension

Clinician's Notes

F. Dermatological

Skin Problems _____

G. Endocrine

Hot/ Cold Sensitivity Appetite Awareness Perimenopausal /
 Excessive Thirst Incontinence Menopausal Symptoms
 PMS Sugar Sensitivity
 Diabetes Thyroid Disorder

Clinician's Notes

H. Gastrointestinal

Stomach Pain Chronic Constipation Irritable Bowel Nausea or Vomiting

Clinician's Notes

I. Neurological

Headaches Fainting Tremor or Spasticity
 Coordination Speech Problems Accident Prone
 Weakness Balance
 Motor or Vocal Tics Seizures

Clinician's Notes

J. Orthopedic

___Chronic Pain/ Stiffness
___Chronic Aching Pain

___Low Pain Threshold
___High Pain Tolerance

___Chronic Nerve Pain
(burning or stabbing)

Clinician's Notes

K. Habits (Please indicate both past and present participation)

___Coffee Use ___Alcohol Use ___Cigarette Use ___Other Drug Use

Dietary Habits (Please characterize your general eating habits)

L. Behavior/Emotions

___Mood Swings
___Panic Attacks
___Manic-Depression
___Anxiety
___Irritability

___Eating Disorders
___Depression
___Anger/Aggression
___Addictions
___Fears/Phobias

___Violent Behavior
___Risk-Taking Behavior
___Obsessive Compulsive
Symptoms

Clinician's Notes

M. Academic and Cognitive

___Attention Span
___Sense of Direction
___Math
___Spatial Skills
___Art
___Distractibility

___Verbal Expression
___Writing
___Memory
___Impulsivity
___Reading

___Problems with
Homework
___Academic Strengths /
Weaknesses
___Recurrent Complaints
from Supervisors

N. Home Behavior

___Recurrent Problems with Neighbors

___Recurrent Problems with Relatives

Clinician's Notes

II. Personal History

A. Perinatal

Prenatal Stress or Injury
 Difficult Birth
 Adopted at age

Prenatal Drug Exposure
 Premature or Late Birth
 Difficult Labor

Medical Problems after Birth

B. Growth and Development

Colic
 Activity Level
 Motor Development
 Chronic Ear Infections

Sleep Problems
 Attachment
 Allergies
 Asthma

Eating Problems
 Emotional Development
 Language Development

C. Physical Traumas

Head Injury
 Serious Illness
 Poisoning

Accidents
 CNS Infection
 Anoxia

Extreme Fever
 Overdose
 Stroke

D. Psychological Traumas and Stresses

Abuse or Neglect Family Stress Death in Family Illness

E. Spiritual (Please be as specific as possible, estimating frequency of involvement)

Prayer Fasting Meditation Bible/Wisdom Literature Reading Other

Denominational Affiliation: _____

Clinician's Notes

Treatment History

Medications: (Use backside if more room is needed)

Medication	For Condition	Dose	Dates

Medical Treatment:

Procedure	For Condition	Physician Address/Phone	Dates

Psychological Therapy:

Therapy	For Condition	Therapist Address/Phone	Dates

Other Therapy:

Therapist	For Condition	Therapist Address/Phone	Dates

Family History

Symptom	Yes	No	Relationship to You
Asthma			
Autoimmune Disorders: Type 1 Diabetes, Rheumatoid Arthritis, Lupus, MS, Scelorderma, etc.			
Migraine			
Sleep Problems			
Depression			
Manic-Depression			
Anxiety			
Phobias			
Panic Attacks			
Motor or Vocal Tics			
Eating Disorders or Obesity			
Addictions			
Obsessive Compulsive Symptoms			
Speech Problems			
Attention Problems			
Learning Problems			
Conduct Problems or Criminal			
Behavior			
Autism Spectrum			
Schizophrenia			