

The Art, Science & Practice of Healthy Living

Sara AlRawi, ND MPH

Adult Intake

PATIENT INFORMATION

Full Name: _____ Date: _____

Date of birth _____ (MM/DD/YY) Gender: Male Female

Full Address: _____

Telephone number: (home): _____ (work): _____
(mobile): _____

Email: _____

May we leave you phone messages/ call to confirm & cancel appointments? Y / N

Emergency contact: Name: _____

Phone number: _____ Relation: _____

Who may we thank for referring you to our clinic: _____

Other health care providers you are seeing:

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

MEDICAL HISTORY

Please list your health concerns in order of importance.

Concern	Since	Concern	Since
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Have any of these issued changed or worsened over time?

What effect have these issues had on your life?

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

Please list any major trauma, injury, illness or accident you have sustained.

Incident	Date	Long-term effects

Please list any surgical procedures you have undergone.

Procedure	Date	Complications/ Results

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

Please list any other forms of treatment that you have used and describe their effectiveness

CHILDHOOD ILLNESSES & VACCINATIONS: (circle all that apply)

- Chicken pox Measles Mumps Rheumatic Fever Roseola Polio
- Scarlet Fever Tuberculosis Impetigo Whooping Cough Mononucleosis
- Strep Throat Rubella (German measles) Ear Infections

Were you vaccinated as a child?

Any known side effects?

Any additional vaccinations (i.e. Hepatitis A or B, "Flu Shot". Etc)?

MEDICATIONS/ SUPPLEMENTS/ DRUGS

Please list all current medications and supplements you take including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

Drug/ Supplement	Used For	Date Started	Dosage/ Frequency

In the last five years, how many courses of antibiotics have you taken? _____

When was the most recent course of antibiotics? _____

Which of the following have you used/ do you currently use? Please include amount, frequency, duration of use.

Tobacco	Alcohol
Recreational Drugs	Steroids
Cortisone	Antacids
Sedatives	Laxatives
Coffee	Other

ALLERGIES, SENSITIVITIES, EXPOSURES

Please list any known or suspected allergies, sensitivities and/ or intolerances.

Drugs	Food	Environmental/Chemical

Have you ever been exposed to toxic substances such as pesticides, herbicides, solvents, or sprays? If yes, please explain _____

Have you ever been exposed to heavy metals such as lead, mercury, arsenic, cadmium, or second hand smoke? If yes, please explain _____

Have you ever had to lower the regular dose of prescription, over-the-counter medication, homeopathic or herbal formula because you were too sensitive to the regular dose? _____

FAMILY HISTORY

Please indicate if any of your immediate family (parents, siblings, maternal and paternal grandparents) suffers from or has suffered from any of the following conditions.

Condition	Family Member (s)	Condition	Family Member (s)	Condition	Family Member (s)
Alcoholism/ Drug use		Colitis		Kidney Disease	
Allergies/ Hay fever		Depression		Liver Disease	
Asthma		Diabetes		Overweight/ Obesity	
Arthritis		Heart Disease		Prostate Cancer	
Breast Cancer		High Blood Pressure		Other Cancer	
Colon Cancer		Hyper/ Hypothyroidism			
Mental Illness		Stroke			

I don't know my family medical history

DIET & DIGESTION

Current Weight: _____ Desired Weight (if different): _____

Maximum Weight: _____ When? _____

Minimum Weight: _____ When? _____

Have you gained or lost any weight in the past 6-12 months? Y N

If yes, how much? _____

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	

LIFESTYLE

What is your occupation? _____

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

Do you exercise regularly? Y / N

What do you do for exercise, how much, how often?

How would you describe the emotional climate of your home?

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