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Hydrostone Osteopathy
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ADULT INTAKE FORM

Name _____ Date of Birth _____

Address _____

Home Phone _____ Work/Cell Phone _____

Occupation(s) _____

How did you find out about the naturopathic services at this clinic? _____

Emergency Contact

Name _____ Relationship to you _____

Address _____ Phone _____

Other Health Care Providers

Name	Title	Location	Phone

Extended healthcare insurance company (if applicable) _____

What are your main health concerns?

_____

_____

_____

_____

_____

How would you describe your overall state of health?

___ very poor ___ poor ___ fair ___ good ___ very good ___ excellent

List any accidents, injuries, hospitalizations (including type and year of occurrence)

_____

_____

_____

List any known allergies (including food, drugs, insects, herbs, environmental)

_____

_____

_____

List any abnormal test results that you are aware of (eg. high cholesterol, low iron, etc.)

_____

_____

_____

Medications & Supplements (including vitamins, minerals, herbs, etc.)

Name (Brand)	Daily Dose	Name (Brand)	Daily Dose

Immunizations _____

Any reactions to vaccines? _____

Have you ever taken antibiotics? (Y/N) ____ Approximate number of times _____

Have you ever taken corticosteroids? (Y/N) ____ Approximate length of time _____
(e.g. prednisone, hydrocortisone cream, inhaler for asthma)

Do you smoke? ____ How much? _____ For how long? _____

Did you smoke in the past? ____ How much? _____ For how long? _____

Family History List any serious illnesses of close relatives (parents, siblings, children, grandparents, aunts, uncles)

Relation	Age	Illness (eg. cancer, diabetes, heart disease, mental illness, alcoholism, lung disease, kidney disease)

Review of Systems

Indicate with a "C" if you currently experience any of these, and "P" if you did in the past:

Gastrointestinal System

___ difficulty swallowing
___ heartburn/indigestion
___ acid reflux/gastritis
___ nausea after eating
___ feel full easily
___ hiatal hernia
___ burping
___ abdominal pain/cramps
___ ulcer
___ bloating
___ flatulence
___ loose stools
___ diarrhea
___ constipation
___ undigested food in stool
___ irritable bowel syndrome
___ Crohn's or colitis
___ hemorrhoids
___ hernia
___ liver disease
___ gall bladder disease
___ food cravings
___ large change in appetite
___ large change in thirst

Other/comments _____

Head & Neck

___ headaches
___ migraines
___ head injury
___ jaw/TMJ problems
___ wear glasses/contacts
___ vision disturbances
___ spots in vision
___ eye pain
___ eye itching
___ eye redness
___ dry eyes
___ eye discharge
___ glaucoma
___ cataracts
___ impaired hearing
___ ear infection
___ ringing in ears
___ frequent runny nose
___ hay fever/allergies
___ nose bleeds
___ sinus problems
___ loss of smell
___ cold sores
___ teeth grinding
___ gum problems
___ sensitive teeth
___ cavities (#: ____)
___ dry mouth
___ canker sores
___ sore lymph nodes

Other/comments _____

Cardiovascular & Neurological Systems

___ heart disease
___ high blood pressure
___ low blood pressure
___ high cholesterol
___ angina
___ chest pain
___ heart palpitations
___ heart murmurs
___ blood clots
___ phlebitis
___ varicose veins
___ swelling in arms/legs
___ cold hands/feet
___ easy bleeding
___ easy bruising
___ anemia
___ fainting
___ dizziness or vertigo
___ numbness or tingling
___ seizures
___ balance problems
___ concussion
___ twitches

Other/comments _____

Infections & Immunity

___ frequent colds
___ slow wound healing
___ chicken pox
___ measles
___ rubella
___ mononucleosis
___ mumps
___ whooping cough
___ tonsilitis
___ Strep throat
___ sinusitis
___ abscess
___ peritonitis
___ malaria
___ tuberculosis
___ hepatitis
___ urinary tract infection
___ kidney infection
___ genital warts
___ gonorrhea
___ herpes
___ chlamydia
___ syphilis

Other/comments _____

How often do you get colds, flu and/or sore throat in a year? _____

Skin/Hair

___ rash
___ eczema
___ hives
___ acne
___ boils
___ cysts
___ warts
___ psoriasis
___ itching
___ large scars
___ sunburn
___ hair loss
___ dandruff
___ dry skin
___ change in skin color
___ numerous moles
___ change in mole(s)
___ perspire easily
___ rarely perspire
___ night sweats
___ nail infection
___ brittle nails

Other/comments _____

Have you ever had any skin conditions/lesions removed or biopsied?_____

Respiratory System

___ chronic cough
___ coughing blood
___ asthma
___ wheezing
___ shortness of breath
___ difficulty breathing
___ pain on breathing
___ chronic mucus/phlegm
___ bronchitis
___ pleurisy
___ pneumonia

Other/comments _____

Musculoskeletal

___ broken bone(s)
___ joint pain
___ joint stiffness
___ joint swelling
___ muscle spasms/cramps
___ muscle twitches
___ arthritis
___ neck stiffness
___ neck pain/soreness
___ back stiffness
___ back pain/soreness
___ sciatica
___ disk problems
___ muscle pain at night
___ restless legs at night

Other/comments _____

Female

___ PMS
___ painful period
___ heavy flow
___ discharge btw. periods
___ vaginal discharge
___ vaginal itching
___ vaginitis
___ yeast infection
___ abnormal PAP result
___ endometriosis
___ ovarian cysts
___ uterine fibroids
___ cervical dysplasia
___ difficulty conceiving
___ pain during intercourse
___ sexual difficulties
___ hot flushes
___ breast pain/tenderness
___ breast lumps
___ nipple discharge
___ fibrocystic breasts

Other/comments _____

Age at first menstruation _____ Age at menopause _____

Typical length of cycle _____ Typical duration of flow _____ Are cycles regular? ____

Date of last PAP _____ Do you do breast self exams? _____ How often? _____

Please indicate the years of any pregnancies / births:

_____

Male

___ hernia
___ testicular pain
___ testicular masses
___ prostate enlargement (BPH)
___ prostatitis
___ discharge/sores
___ sexual difficulties
___ infertility
___ abnormal PSA result

Other/comments_____

Other

___ pain with urination
___ difficulty urinating
___ incontinence
___ kidney stones
___ kidney disease
___ thyroid problem
___ diabetes
___ hypoglycemia
___ hormone therapy
___ fibromyalgia
___ chronic fatigue
___ seasonal depression (SAD)

Comments _____

Height _____ Weight _____ Blood Type (if known) _____

Highest adult weight _____ Lowest _____

How much stress do you have in your life? _____

How would you describe your ability to cope with stress? _____

Do you ever experience (Y/N): Wide mood swings _____ Anxiety _____ Depression _____

How would you rate your overall level of energy? (1=poor, 10=excellent) _____

At what time of day is your energy highest? _____ Lowest? _____

How would you rate your overall quality of sleep? (1=poor, 10=excellent) _____

Do you have trouble falling asleep or staying asleep? Yes / No

Do you take any naps during the day? Yes / No How many? _____ How long? _____

Do you ever feel dizzy when you rise up quickly from sitting or lying? Yes / No

How would you describe your temperature? (circle) Often chilly Average Often warm

Please describe a typical day's diet

Breakfast _____

Lunch _____

Supper _____

Snacks _____

Beverages _____

Exercise (types and frequency) _____

_____

What are your main hobbies/interests? _____

_____

What do you enjoy most in your life? _____

_____

What do you do to support your health? _____

_____

Is there anything else you feel I should know? _____

_____