



## Medication Form

Name: \_\_\_\_\_ Date Completed: \_\_\_\_\_

Address: \_\_\_\_\_

Phone Number: \_\_\_\_\_ Birth Date: \_\_\_\_\_

Emergency Contact/ Phone: \_\_\_\_\_

E-Mail \_\_\_\_\_

(We give notice of any important changes and sales through e-mail. We will not send any notification by post mail.)

Allergies and Drugs to Avoid/Adverse Reactions:

\_\_\_\_\_

Please list any other special dietary information, or foods you can or will not eat. (ex: vegan, vegetarian, etc.)

\_\_\_\_\_

\_\_\_\_\_

### Current Medications:

*List all medications you are taking, include over-the-counter (e.g., supplements, prescriptions, aspirin, antacids).*

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_ Directions: \_\_\_\_\_

Date Started: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_ Directions: \_\_\_\_\_

Date Started: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_

Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_ Directions: \_\_\_\_\_

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Medication: \_\_\_\_\_ Dosage: \_\_\_\_\_

Reason for Taking: \_\_\_\_\_ Directions: \_\_\_\_\_

Date Started: \_\_\_\_\_ Date Discontinued: \_\_\_\_\_

Immunization Record:  
(Include dates administered)

Tetanus \_\_\_\_\_  Pneumonia Vaccine \_\_\_\_\_  Flu Vaccine \_\_\_\_\_

Hepatitis Vaccine \_\_\_\_\_  Other \_\_\_\_\_



## ADULT INTAKE FORM

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Age: \_\_\_\_\_

List in Order of importance what your problems are:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_

Last time you had blood work done and with what physician: \_\_\_\_\_

### Family History

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living	_____	_____	_____	_____	_____	_____
Age when died	_____	_____	_____	_____	_____	_____
Reason for death	_____	_____	_____	_____	_____	_____
Cancer type	_____	_____	_____	_____	_____	_____
High Blood Pressure	Y N	Y N	Y N	Y N	Y N	Y N
Heart Attack/Stroke	Y N	Y N	Y N	Y N	Y N	Y N
Heart Disease	Y N	Y N	Y N	Y N	Y N	Y N
Asthma/Allergies	Y N	Y N	Y N	Y N	Y N	Y N
Mental Illness	Y N	Y N	Y N	Y N	Y N	Y N
TB	Y N	Y N	Y N	Y N	Y N	Y N
Auto-Immune Disease	Y N	Y N	Y N	Y N	Y N	Y N
Diabetes Mellitus	Y N	Y N	Y N	Y N	Y N	Y N
Osteoporosis	Y N	Y N	Y N	Y N	Y N	Y N

List All Surgeries & Hospitalizations, including date occurred:

- |          |          |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Please Note When & Why You Have Had Each of the Following:

X-Rays: \_\_\_\_\_ MRI/Cat Scans: \_\_\_\_\_

Ultrasounds: \_\_\_\_\_ Accidents: \_\_\_\_\_

TB Test: \_\_\_\_\_ HCV: \_\_\_\_\_

HIV: \_\_\_\_\_ Last Dental Visit: \_\_\_\_\_

Last Eye Exam: \_\_\_\_\_

Did you have the following Disease (D), Get Immunized (I), or Neither (N):

Measles: D I N	Chicken Pox: D I N	Mumps: D I N	Rubella: D I N
Tetanus: D I N	Whooping Cough: D I N	Hemophilus (Hib): D I N	Hepatitis B: D I N

German Measles: D I N Any vaccination reactions: \_\_\_\_\_  
 Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

List Yes (Y), No (N) or Past (P) regarding use of the following:

Antacids: Y N P Steroids: Y N P Smoking: Y N P Packs per day & number of years: \_\_\_\_\_  
 Analgesics: Y N P Laxatives: Y N P Coffee: Y N P Cups per day if Yes/Past: \_\_\_\_\_  
 Soda Pop: Y N P Ounces per day if Yes/Past: \_\_\_\_\_  
 Alcohol: Y N P How often & how much if Yes/Past: \_\_\_\_\_  
 Any Alcohol Addiction: Y N P Any Alcohol Treatment: Y N P  
 Recreational Drugs: Y N P Any Drug Addictions: Y N P  
 Any Drug Treatment: Y N P

List all Prescription Medicines & Nutrient Supplement/Herbs that you are taking and include dosage if known:

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

**Review of Systems:**

Present Weight: \_\_\_\_\_ Weight one year ago: \_\_\_\_\_ Height: \_\_\_\_\_  
 Ideal Weight: \_\_\_\_\_

REGARDING THE NEXT LONG SECTION: Please circle (Y) if you have the problem NOW, (N) if you've NEVER had the problem, (P) if you had the problem in the PAST.

Good Energy: Y N P  
 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

<u>SKIN</u>				
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
<u>HEAD</u>				
Headache:	Y N P		Migraine:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oil/dry hair:	Y N P		Hair loss:	Y N P
<u>NOSE</u>				
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

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

<u>EYES</u>				
Dry/Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Cataracts/Glaucoma:	Y N P
Glasses:	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
<u>MOUTH/THROAT</u>				
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 taste:	Y N P		Hoarseness:	Y N P
<u>NECK</u>				
Stiffness:	Y N P		Swollen Glands:	Y N P
Full movement:	Y N P		Tension:	Y N P
<u>RESPIRATORY</u>				
Cough:	Y N P		TB:	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
<u>CARDIOVASCULAR</u>				
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
<u>URINARY TRACT</u>				
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
<u>GASTROINTESTINAL</u>				
Heartburn:	Y N P		Bowel Movement Freq:	
Indigestion:	Y N P		Recent BM Change:	Y N P
Bloating:	Y N P		Diarrhea/Constipation:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P
Vomiting:	Y N P		Gall Bladder Disease	Y N P
Change in Appetite:	Y N P		Liver Disease:	Y N P
Pancreatitis:	Y N P		Ulcer	Y N P

<u>MALE GENITALIA</u>				
Testicular pain/swelling:	Y N P		Sexually Active:	Y N P
Hernia:	Y N P		S.T.D.:	Y N P
Discharge:	Y N P		Prostate Disease/Symptoms:	Y N P
Impotency:	Y N P		Sexual Orientation:	Hetero Homo Bi

<u>FEMALE GENITALIA</u>			
Age Period Began:		How Often Period Occurs:	
How long period lasts:		Heavy menstrual bleeding:	Y N P
Menstrual cramping:	Y N P	Menstrual Pain:	Y N P
PMS:	Y N P	Start date of last period:	
Times Pregnant:		How many births:	
Miscarriages:		Abortions:	
Last Pap Smear:		Diagnosis:	
Any abnormal paps:	Y N P	When was abnormal:	
Menopausal since what age:		Use of hormones:	Y N P
Type of hormones used:		Healthy libido:	Y N P
Dry vagina:	Y N P	Sexually Active:	Y N P
Pain w/ Intercourse:	Y N P	Vaginitis:	Y N P
S.T.D.:	Y N P	Mammography:	Y N P
Dexa Scan:	Y N P	If Yes, what were results:	
Sexual Orientation:	Hetero Homo Bi		

Please list any birth control used and ages used: \_\_\_\_\_

<u>MUSCULOSKELETAL</u>				
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

<u>NERVOUS</u>				
Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

<u>Mental/Emotional</u>				
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

Patient Name: \_\_\_\_\_

DOB: \_\_\_\_\_

### Exercise

How often do you exercise? \_\_\_\_\_ What type of exercise? \_\_\_\_\_

For how long? \_\_\_\_\_ Hobbies: \_\_\_\_\_

### Sleep

How long per night? \_\_\_\_\_ If you wake up frequently, what is the reason? \_\_\_\_\_

Nightmares: Y N P      Wake Refreshed: Y N P      Must nap during the day: Y N P

Sleep walk: Y N P      Grind teeth: Y N P      Snore: Y N P

### Toxin Exposure

Did you grow up near any refinery, polluted area or in a home with leaded paint? If so, what sort of pollution were you exposed to? \_\_\_\_\_

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials? \_\_\_\_\_

Have you ever had health problems when you put in new carpeting, painted your home, had new cabinets or did other refurbishing? \_\_\_\_\_

Are you particularly sensitive to perfumes, gasoline or other vapors? \_\_\_\_\_

Do you use pesticides, herbicides or other chemicals around your home? \_\_\_\_\_

### Social Life

Enjoy job: Y N P      Hours worked per week: \_\_\_\_\_      Excessive exposure to environmental toxins: Y N P

Quality of significant relationship: \_\_\_\_\_

History of sexual, mental/emotional, physical abuse: Y N P      If so, at what age and by whom: \_\_\_\_\_

What is your greatest health concern: \_\_\_\_\_

How does it limit you the most: \_\_\_\_\_

How committed are you towards making valuable changes:      Little      Moderately      Very

Ethnic Background: \_\_\_\_\_

### Typical Day's Diet

Breakfast: \_\_\_\_\_

Lunch: \_\_\_\_\_

Dinner: \_\_\_\_\_

Snacks: \_\_\_\_\_

### Allergies

List all known Allergies (food, drugs, environment): \_\_\_\_\_

