

ADULT INFORMATION FORM

NAME: _____

DATE: _____

Please fill out the following information as accurately as possible. This information will help the doctor with diagnosis and treatment plans.

Please List SPECIFIC HEALTH CONCERNS in Order of Importance to You:

1. _____

Date Began: ____/____/____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this? Yes ___ No ___

If yes, what medications or treatments were given? _____

2. _____

Date Began: ____/____/____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this? Yes ___ No ___

If yes, what medications or treatments were given? _____

3. _____

Date Began: ____/____/____

What makes it better? _____ Worse? _____

Have you seen other health care providers for this? Yes ___ No ___

If yes, what medications or treatments were given? _____

Do you have any opinions regarding what may have caused your health conditions? _____

Do you have any specific goals for your health? _____

Medical History

ALLERGIES (Medications, Food, Environmental): _____

Past SURGERIES/HOSPITALIZATIONS (include surgery for tonsils, appendix, gall bladder, cosmetic):

Surgery: _____ Date: _____

Name of Hospital: _____ Outcome: _____

Surgery: _____ Date: _____

Name of Hospital: _____ Outcome: _____

Other Hospitalization: _____ Date: _____

Treatment: _____ Outcome: _____

Other Hospitalization: _____ Date: _____

Treatment: _____ Outcome: _____

Injury: _____ Date: _____

Treatment: _____ Outcome: _____

Injury: _____ Date: _____

Treatment: _____ Outcome: _____

Please check if you or a relative have experienced any of the following:

Place an S for self, R for relative and indicate whom.

Alcoholism Hemophilia

Allergies High Blood Pressure

Anemia High Cholesterol

Arthritis Mental Health Condition

Asthma Migraines

Auto Immune Disorder Obesity

Cancer (Type?) Osteoporosis

Depression Other Addiction

Diabetes Psoriasis

Eczema Seizures

Glaucoma Sickle Cell Anemia

Gonorrhea Skin Disorder

Gout Stroke

Hay fever Syphilis

Heart Attack Suicide Attempt

Heart Disease Thyroid Disorder

Gallbladder Eating Disorder (Anorexia, Bulimia, compulsive overeating)

Other

Current Health Information

Please List MEDICATIONS You Are Taking:

Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:
Med:	Dosage:	Times/Day:	Doctor:

Please List SUPPLEMENTS/HERBS You Are Taking:

Type: Reason for Taking:	Dosage:	Times/Day:	Doctor:
Type: Reason for Taking:	Dosage:	Times/Day:	Doctor:
Type: Reason for Taking:	Dosage:	Times/Day:	Doctor:
Type: Reason for Taking:	Dosage:	Times/Day:	Doctor:

Please Check Any of the Following:

<input type="checkbox"/> Smoke	How Long:	Number/Day:	Quit Date:
<input type="checkbox"/> Alcohol	Type:	How Often:	Quit Date:
<input type="checkbox"/> Caffeine	What Drink:	How Often:	
<input type="checkbox"/> Sugar	How Much:	How Often:	
<input type="checkbox"/> Artificial Sweetener	Type:	How Often:	
<input type="checkbox"/> Exercise	Type:	How Often:	
<input type="checkbox"/> Food Cravings	What:	How Often:	
<input type="checkbox"/> Sleep Problems	Type:	How Often:	
<input type="checkbox"/> Recreational Drug Use	How Long:	How Often:	Quit Date:
<input type="checkbox"/> Weight Change:	Gain/Loss:	When:	
<input type="checkbox"/> Diet Restrictions:	What:		

Typical Diet (what you normally eat, not what you think you *should* eat):

Breakfasts:

Lunches:

Dinners:

Snacks:

Fluids:

Average Sleep Per Night (*actual amount, rather than ideal amount*):

Number of Hours Per Night _____ Continuous/Interrupted (please circle one)

Additional comments: