

INTAKE FORM



PERSONAL INFORMATION

Full Name :

Place of Birth : Date of Birth :
D D M M Y Y

Full Address :

Status : Single Married Divorce Others Religion :

E-Mail :

Phone Number : Gender : Male Female

MEDICAL INFORMATION

List of Previous Medical Conditions/Medications/Allergies: (Please indicate any conditions you currently have)

Diabetes Asthma

Hypertension (High Blood Pressure) Allergies

Hyperlipidemia (High Cholesterol) Other (please specify): _____

Heart Disease

HOUSEHOLD INFORMATION

Others in your home :

Smoke detectors available: Yes No Recent loss: Yes No

LIST OF CURRENT HEALTHCARE PROVIDERS

Name :

Phone Number : Fax :

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Current Medical Equipment in Use:

Living Will and Durable Power of Attorney: Yes No

PHYSICAL ACTIVITY

Number of Days of Physical Activity per Week:

Limitations:

Average Daily Steps (Approx.):

DIETARY HABITS

Number of Meals per Day:

Servings of Fruits/Vegetables per Day:

Daily Water Consumption (in liters):

Other Drinks Consumed: (Soda, Energy Drinks, Coffee, Alcohol, Wine)

GENERAL HEALTH

Y

Self-rated Health: Poor Fair Good Very Good Excellent

Annual Dental Exams: Yes No Annual Vision Exams: Yes No

MENTAL HEALTH

Major Stressors:

Quality of Sleep: Poor Fair Good Very Good Excellent

Church Affiliation: Yes No Support System: Yes No

Recent Feelings (Past 2 Weeks):

Anxious: Yes No Depressed: Yes No Suicidal: Yes No

Safety Habits:

Always Fasten Seatbelt: Yes No Always Use Helmet for Bike Rides: Yes No

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Frequency of Stress (Health, Finances, Family, Work, Relationships):

Health :

Finances :

Family :

Work :

Relationships :

SOCIAL HABITS

Smoking Habits :

Cigarettes : Yes No Pipe : Yes No Frequency/Amount:

Alcohol Consumption:

Liquor: Yes No Beer: Yes No Wine: Yes No Frequency/Amount:

Use of Street Drugs: (Marijuana, Cocaine, Heroin) Frequency/Amount:

Vaping/Nicotine Replacement Products: Yes No

Sexual Activity : Yes No Number of Partners in the Past 3 Months:

Barrier Use : Yes No

History of STIs :

Type : Current Contraception: Yes No

FEMALE-SPECIFIC QUESTIONS

Number of Pregnancies: Number of Children:

Menstrual Information:

Still having monthly periods: Yes No Regularity: Regular Irregular

Flow: Light Moderate Heavy Folic Acid Use: Yes No

Hormonal/OTC Products: Yes No Urinary Incontinence/Frequency/Urgency: Yes No

Menopausal Symptoms:

Hot Flashes: Yes No Vaginal Dryness: Yes No

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MALE-SPECIFIC QUESTIONS

Libido/Erection Problems: Yes No

Use of Viagra/Cialis/OTC Meds for Sex: Yes No

ELDERLY-SPECIFIC QUESTIONS

Number of Falls in the Past 12 Months: Ambulation/Balance Problems: Yes No

Use of Viagra/Cialis/OTC Meds for Sex: Yes No

Hearing/Vision Problems: Yes No Memory/Speech Problems: Yes No

Family History:

Memory Problems: Yes No

Need Assistance with Activities of Daily Living (ADL): Yes No Specify:

Need Assistance with:

Finances Cooking Managing Money Shopping Transportation

Family Medical History:

AAA (Abdominal Aortic Aneurysm)

Dementia

Cancers (Breast, Colon, Ovarian, Cervical, etc.) and Age of Onset:

Heart Disease and Early Deaths:

Men (Age < 55 years old)

Women (Age < 60 years old)

Overweight/Obesity

Hypertension (HTN)

Hyperlipidemia (HLD)

Diabetes Mellitus (DM)

THANK YOU FOR YOUR INFORMATION