THECLOVERCLINIC
Your Choice for Wellness

Adult Intake Form

Patient Privacy: Patient information will never be disclosed or sold to an individual or company. The information you provide herein is used solely by us for administrative, diagnostic, and/or treatment purposes, and will be treated in the strictest confidence.

Name
Address:
City
State Zip
Email Address:
Age: Gender: Date of Birth:

Date
Telephone:
Alt. Telephone
Marital Status:
Live With:

Occupation:
Employer:

Hours Per Week:
Work Address:

How did you hear about us?

Do you have any family members that are patients with us?

Emergency Contact Name:
Emergency Contact Number:

Relationship to you:
Address:

CONTEXT OF CARE REVIEW: Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your responses to the following questions will go a long way in assisting our understanding of your truest desires. Your time, thoughtfulness, and honesty in completing this overview will greatly aid us to assist your health needs.

Why did you choose to come to us:

What do you know of our approach to wellness?

What three (3) expectations do you have from this visit?

What long term expectations do you have of our doctor?

What is your present level of commitment to address any underlying causes of your signs/symptoms that relate to your lifestyle? (Please rate on a scale of 1 to 10, 10 being totally committed)

1 2 3 4 5 6 7 8 9 10

What behaviors/habits do you currently engage in regularly that you believe support your health?

What behaviors/habits do you currently engage in regularly that you believe are self-destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Wellness is a balance of many factors. By choosing a number in each scale, rate your level of satisfaction in each area of your life. For example, if you are extremely happy with your career, choose 9 or 10. Do the same for each area of your life.

- [ ] Physical Environment
- [ ] Career
- [ ] Money
- [ ] Health
- [ ] Significant Other/Romance
- [ ] Fun & Recreation
- [ ] Personal Growth
- [ ] Family & Friends

Are you currently receiving health care? Yes ◉ No ○

If yes, where and from whom?

If no, when and where did you last receive medical or health care?

What was the reason?

What are your most important health problems? List as many as you can in order of importance:

Do you have any contagious diseases at this time? Yes ○ No ○

If yes, what?

FAMILY HISTORY

Do you have a family history of any of the following?

☐ Cancer	☐ Arthritis	☐ Mental Illness	☐ Kidney Disease
☐ Epilepsy	☐ Asthma	☐ Hives	☐ Stroke
☐ Anemia	☐ Heart Disease	☐ Tuberculosis	☐ High Blood Pressure
☐ Diabetes	☐ Glaucoma	☐ Hay Fever	

Any other relevant family history?

What is your heritage?

CHILDHOOD ILLNESS

☐ Scarlet Fever	☐ Diphtheria	☐ Rheumatic Fever
☐ Mumps	☐ Measles	☐ German Measles

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

ALLERGIES

Are you hypersensitive or allergic to any drugs?

Any foods?

Any environmental influences or chemicals?

CURRENT MEDICATIONS

Do you take or use .....

- ☐ Laxatives
- ☐ Cortisone
- ☐ Tranquilizers
- ☐ Pain relievers
- ☐ Appetite suppressants
- ☐ Thyroid medication
- ☐ Antacids
- ☐ Antibiotics
- ☐ Sleeping pills

Please list any prescription and OTC medications, vitamins, or other supplements you are taking:

GENERAL

Height: Weight: Weight 1 year ago:

Maximum Weight: When:

When during the day is your energy the best? Worst?

TYPICAL FOOD INTAKE

Breakfast:

Lunch:

Dinner:

Snacks:

To Drink:

HABITS

Main interests and hobbies?

Do you exercise?

If yes, what kind?

How often?

Watch television?

How many hours/day?

Do you read?

How many hours/day?

Do you have a religious or spiritual practice?

If yes, what?

Smoked previously?

How many years?

How many cigarettes/day?

Y = CONDITION YOU HAVE NOW **N = NEVER HAD** **P = PROBLEM IN PAST**

Average 6-8 hours sleep daily		Take vacations	
Sleep well		Spend time outside	
Awaken rested		Eat 3 meals/day	
Have a supportive relationship		Go on diets often	
Have a history of abuse		Eat out often	
Experienced major traumas		Drink coffee	
Used recreational drugs		Drink black tea/green tea	
Been treated for drug dependence		Drink cola/other pop	
Use alchoholic beverages		Drink or eat refined sugar	
Been treated for alcoholism		Add salt to food	
Enjoy your work			

REVIEW OF SYSTEMS

Y = CONDITION YOU HAVE NOW **N = NEVER HAD** **P = PROBLEM IN PAST**

MENTAL / EMOTIONAL

Treated for emotional problems		Depression	
Mood swings		Anxiety or nervousness	
Considered or attempted suicide		Tension	
Poor concentration		Memory problems	

IMMUNE

Reactions to immunizations		Reactions to vaccinations	
Chronic Fatique Syndrome		Chronic infections	
Chronically swollen glands		Slow wound healing	

ENDOCRINE

Hypo/hyperthyroid		Heat or cold intolerance	
Hypoglycemia		Diabetes	
Excessive thirst		Excessive hunger	
Fatique		Seasonal depression	

NEUROLOGIC

Seizures		Paralysis	
Muscle weakness		Numbness or tingling	
Loss of memory		Easily stressed	
Vertigo or dizziness		Loss of balance	

SKIN

Rashes		Eczema, Hives	
Acne, boils		Itching	
Color change		Perpetual hair loss	
Lumps		Night sweats	

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HEAD

Headaches		Head injury	
Migraines		Jaw/TMJ problems	

EYES

Spots in eyes		Cataracts	
Impaired vision		Wear glasses or contacts	
Blurriness		Eye pain or strain	
Color blindness		Tearing or dryness	
Double vision		Glaucoma	

EARS

Impaired hearing		Ringing	
Earaches		Dizziness	

NOSE AND SINUSES

Frequent colds		Nose bleeds	
Stuffiness		Hay fever	
Sinus problems		Loss of smell	

MOUTH AND THROAT

Frequent sore throat		Copious saliva	
Teeth grinding		Sore tongue or lips	
Gum problems		Hoarseness	
Dental cavities		Jaw clicks	

NECK

Lumps		Swollen glands	
Goiter		Pain or stiffness	

RESPIRATORY

Cough		Sputum	
Spitting up blood		Wheezing	
Asthma		Bronchitis	
Pneumonia		Pleurisy	
Emphysema		Difficulty breathing	
Pain on breathing		Shortness of breath	
Shortness of breath at night		Shortness of breath laying down	
Tuberculosis			

CARDIOVASCULAR

Hearth disease		Angina	
High or low blood pressure		Murmurs	
Blood clots		Fainting	
Rheumatic fever		Palpitations/fluttering	
Swelling in ankles		Chest pain	

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GASTROINTESTINAL

Trouble swallowing		Heartburn	
Change in thirst		Abdominal pain or cramps	
Change in appetite		Belching or passing gas	
Nausea or vomiting		Constipation	
Ulcer		Diarrhea	
Jaundice (yellow skin)		Bowel movements: How often?	
Gall Bladder disease		Is this a change?	
Liver disease		Black stools	
Hemorrhoids		Blood/mucus in stool?	

URINARY

Pain on urination		Increased frequency	
Frequency at night		Inability to hold urine	
Frequent infections		Kidney stones	

MUSCULOSKELETAL

Joint pain or stiffness		Arthritis	
Broken bones		Weakness	
Muscle spasms or cramps		Sciatica	

BLOOD/PERIPHERAL VASCULAR

Easy bleeding or bruising		Anemia	
Deep leg pain		Cold hands/feet	
Varicose veins		Thrombophlebitis	

FEMALE REPRODUCTION/BREASTS

Age at first menses		Date of last annual exam (PAP)?	
Age at last menses		Are cycles regular	
Length of cycle		Bleeding between cycles	
Duration of menses		Pain during intercourse	
Painful menses		Clotting	
Heavy menses		Discharge	
PMS		Birth control	
if Yes, what are your symptoms?		What type?	
Endometriosis		Number of pregnancies	
Ovarian cysts		Number of live births	
Difficulty conceiving		Number of miscarriages	
Cervical dysplasia		Number of abortions	
Sexual difficulties		Menopausal symptoms	
Gonorrhea		Abnormal PAP	
Herpes		Chlamydia	
Are you sexually active		Condyloma	
Do you do breast self exams		Syphilis	
Breast pain/tenderness		Sexual orientation	
Breast lumps		Nipple discharge	