NEW ADULT PATIENT FORM

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Name:_____ Date: _____
Address:_____ Home Phone: _____
City/State/Zip:_____ Cell Phone: _____
Date of Birth: _____ Gender: _____ Referred by: _____

1. Current symptoms, problems, health concerns, and reason for visit: _____
_____
_____
_____

2. Prescription medications: _____
_____

3. Other medications (including over-the-counter meds, supplements, herbs, homeopathic remedies, etc.):
_____
_____

4. Allergies to medications: _____
5. Other allergies (foods, mold, pets, etc.):_____
6. Other food sensitivities:_____
_____

7. Major medical problems (including illnesses, hospitalizations, surgeries, major dental work): _____
_____
_____

8. Describe any traumas, including car accidents, falls, head injuries, sports injuries, fractures (include year occurred):_____
_____
_____
_____
_____

9. Other therapies & treatments that you have used (past or present): _____
_____
_____

10. Describe your exercise routine or level of activity: _____
_____
_____
_____

12. Birth History: Full-term Premature Late C-Section Force-ups/Vacuum Vaginal Delivery (circle)
Any complications? _____
Older Siblings _____ # Younger Siblings _____

13. Did you have orthodontia? When? _____

14. Past Medical History (please check all that apply)

Seizures	☐	Hives/Eczema	☐	Heart Disease	☐
Migraines	☐	Bronchitis	☐	High Blood Pressure	☐
Glaucoma	☐	Ear Tubes	☐	Low Blood Pressure	☐
Stroke	☐	Lyme Disease	☐	Arthritis	☐
Polio	☐	Hepatitis	☐	Bladder Infections	☐
Pneumonia	☐	Anemia	☐	Kidney Disease	☐
Tuberculosis	☐	Ulcer	☐	Easy Bruising	☐
Cancer	☐	Diabetes	☐	Ulcer.colitis/Crohns	☐
Asthma	☐	Rheumatic Fever	☐	Meningitis	☐

Other _____

15. Do you use:

Glasses	☐	Dentures	☐	IUD/Diaphragm	☐
Contact lenses	☐	Pacemaker	☐	Oral contraceptives	☐
Hearing aid	☐	Neck or back brace	☐		

16. Pregnancies: Total _____ Premature _____ Term _____ Abortions/Miscarriages _____ C/Sections _____

17. Last Dental Exam _____

18. Most Recent Routine Labs (Date/Result)
Vit D: _____ LH/FSH: _____
Thyroid Function (TSH/T4): _____ Testosterone: _____
Adrenal Function (Cortisol): _____

19. Other Exams (Date/Result)
☐ Food Sensitivity _____
☐ Saliva/Urine Hormone Testing _____
☐ Hair/Urine Heavy Metal _____
☐ Digestive Function/Stool Analysis _____
☐ Neurotransmitter Testing _____

20. Imaging (Date/Result)
X-ray _____
MRI_____
CT Scan _____
Ultrasound/Sonogram _____

21. Any other abnormal labs or tests? _____

22. Intake
Tobacco (type/amt. per week): _____ Alcohol (type/amt. per week): _____
Caffeine (type/amt. per week): _____ Glasses water per day: _____
Dietary restrictions/preferences: _____
Sodas (# per week) – Diet or regular?_____

23. Sleep: How many hours of sleep do you average? _____
Do you have trouble getting asleep? _____ Staying asleep? _____
Do you take anything to help you sleep? _____ How many days/week? _____

24. Family History (please indicate relationship)

Cancer _____
Leukemia _____
Tuberculosis _____
Depression _____
Bipolar/Schizophrenia _____
Substance Abuse _____
Suicide _____
Migraines _____
Seizures _____
Allergies _____

Asthma _____
Eczema _____
Anemia _____
Heart Disease _____
Chronic Lung Disease _____
Thyroid Disease _____
Kidney Disease _____
Hepatitis _____
Diabetes _____
Bleeding Tendency _____

25. List present age of family members, state of health (good, fair, poor), any major health problems. If deceased, list cause of death & age.

Father _____
Mother _____
Sibling(s) _____
_____
_____
_____

Children _____
_____
_____
_____
Spouse/partner _____

Review of Systems

26. Please mark any symptoms that you are having, or have experienced in the past year

- ☐ Weight gain
- ☐ Weight loss
- ☐ Change in appetite
- ☐ Persistent fever
- ☐ Hot flashes
- ☐ Night sweats
- ☐ Skin rash
- ☐ Change in nails/hair
- ☐ Easy bruises/bleeding
- ☐ Headaches
- ☐ Migraines
- ☐ Double vision
- ☐ Blurry vision
- ☐ Tinnitus
- ☐ Sinusitis
- ☐ Nasal congestion
- ☐ Mouth breathing
- ☐ Shortness of breath
- ☐ Chest pain
- ☐ Palpitations
- ☐ Restless legs
- ☐ Cold hands/feet
- ☐ Heartburn
- ☐ Bloating/belching
- ☐ Flatulence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Abdominal pain
- ☐ Frequent urination
- ☐ Burning w/urination
- ☐ Urinary hesitancy
- ☐ Urinary urgency
- ☐ Heavy periods
- ☐ Premenstrual symptoms

27. Major Stressors in Your Life

- ☐ Personal health
- ☐ Job-related
- ☐ Financial
- ☐ Other _____
- ☐ Marriage
- ☐ Family stress
- ☐ Recent death of family/friends