ADULT INTAKE FORM: Date completed_____ Primary Care Physician _____

Name: _____ **Birth Date:** _____ **Gender:** M F

Marital Status: Married Single Divorced Widowed Separated Common-Law Domestic Partnership

Children: No Yes **How many:** _____Sons _____Daughters

Tobacco Use: N Y Former **Type:** Cigarettes Cigar Pipe Chewing **How much a day**_____ Year started_____ Year Quit_____

Alcohol Use: None Beer Wine Liquor **Amount**: _____ **How often?** daily weekly socially

Substance Use (confidential): None Marijuana Cocaine **Other:** _____**How often?** daily weekly socially

Caffeine Use: None Coffee Tea Soda **How much a day** _____

Do you have a living will N Y do not resuscitate (DNR) order N Y medical power of attorney N Y **Name:** _____

Occupation: _____ **Full Time?** Y N **Part Time?** Y N **Company** _____ **Are you Retired?** Y N

Military Service: No Yes **Branch:** _____

ALLERGIES: _____ **NONE**

Please include reactions to medication, foods, animals, insects. **DO YOU CARRY AN "EPI PEN"?** Y N **MEDICAL ALERT BRACELET?** Y N

Reaction types include HIVES, SWELLING, RASH, ITCHING, HEADACHE, NAUSEA, SHORTNESS OF BREATH, SHOCK, etc.

Name	Reaction

MEDICATIONS: _____NONE I CARRY AN UP-TO-DATE LIST OF MY MEDICATIONS Y N

Please include SUPPLEMENTS, VITAMINS, and NON-PRESCRIPTION MEDICATIONS USED MORE THAN ONCE WEEKLY.

WE CAN PHOTOCOPY A LIST

Name	Dose (for example, milligrams, ounces, etc)	How often? (for example, daily, etc)

MEDICAL HISTORY/SURGICAL HISTORY: _____NONE Please note whether **ACTIVE (A)** or **RESOLVED (R)**

CONDITIONS can include CANCER (specify type), HEART DISEASE, PREGNANCY, DIABETES, BROKEN BONES, ARTHRITIS, etc.

TREATMENT can include SURGERY (specify type), MEDICATION, OTHER PROCEDURES, HOSPITALIZATION, etc.

A	R	Condition or Illness	Treatment	Year

FAMILY HISTORY: _____UNKNOWN _____I AM ADOPTED

Place a check in the appropriate boxes. Please specify if Alive (A) or Deceased (D). If deceased, please CIRCLE the check mark associated with cause of death and WRITE IN THE AGE OF DEATH.

	A	D	First Name	Cancer (type)	Heart disease	Diabetes	Alzheimers	Mental Illness (type)	Other
Father									
Mother									
Brother									
Brother									
Brother									
Sister									
Sister									
Sister									
Son									
Son									
Son									
Daughter									
Daughter									
Daughter									
Dad's Dad									
Dad's Mom									
Mom's Dad									
Mom's Mom									
Uncle									
Aunt									