



ADULT INTAKE

Dr. Monika Lukacena requires a picture of the whole person in order to prescribe individually and effectively. Please complete this form as thoroughly as possible, and it will be further discussed during the first appointment. Please note that this form is completely confidential. Thank you.

DATE _____

NAME _____

SEX M / F

ADDRESS: _____

DATE OF BIRTH (MM/DD/YYYY): ___ / ___ / _____

EMAIL: _____

PHONE: HOME _____ WORK _____ CELL _____

EMERGENCY CONTACT

NAME / RELATION: _____ PHONE: _____

HOW DID YOU HEAR ABOUT OUR CLINIC? _____

OTHER HEALTH CARE PROVIDERS YOU ARE CURRENTLY SEEING:

- | | | | |
|----|------------|-------------|-----------------|
| 1) | NAME _____ | PHONE _____ | SPECIALTY _____ |
| 2) | NAME _____ | PHONE _____ | SPECIALTY _____ |
| 3) | NAME _____ | PHONE _____ | SPECIALTY _____ |
| 4) | NAME _____ | PHONE _____ | SPECIALTY _____ |
| 5) | NAME _____ | PHONE _____ | SPECIALTY _____ |

PLEASE RATE YOUR GENERAL STATE HEALTH (1 = poor, 5 = excellent) 1 2 3 4 5

PLEASE LIST / DESCRIBE YOUR CHIEF CONCERNS (in order of priority):

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL HISTORY:

PLEASE LIST ANY PAST MEDICAL CONCERNS (eg: illnesses, injuries, hospitalizations, surgeries, traumas):

DO YOU HAVE ANY ALLERGIES (MEDICATIONS, SEASONAL, ENVIRONMENTAL, FOOD)?

ALLERGY	REACTION

PLEASE LIST ANY CURRENT MEDICATIONS OR SUPPLEMENTS INCLUDING DOSE:

_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

VACCINATION HISTORY:

PLEASE CHECK THE IMMUNIZATIONS YOU HAVE RECEIVED (comment on any adverse reactions)

- | | |
|---|---|
| <input type="checkbox"/> DPT (diphtheria, pertussis, tetanus) _____ | <input type="checkbox"/> POLIO _____ |
| <input type="checkbox"/> TETANUS BOOSTER _____ | <input type="checkbox"/> CHICKEN POX _____ |
| <input type="checkbox"/> MMR (measles, mumps, rubella) _____ | <input type="checkbox"/> HEPATITIS A _____ |
| <input type="checkbox"/> HEMOPHILUS INFLUENZA B _____ | <input type="checkbox"/> HEPATITIS B _____ |
| <input type="checkbox"/> FLU _____ | <input type="checkbox"/> HPV (Gardasil) _____ |

FAMILY HISTORY:

PLEASE CHECK ANY THAT APPLY:

I DO NOT KNOW MY FAMILY MEDICAL HISTORY

ILLNESS	MOTHER	FATHER	SISTER	BROTHER	MATERNAL GRANDMOTHER	MATERNAL GRANDFATHER	PATERNAL GRANDMOTHER	PATERNAL GRANDFATHER	OTHER
ASTHMA									
ALLERGIES									
HEART DISEASE									
STROKE									
BLOOD PRESSURE									
DIABETES									
KIDNEY DISEASE									
ARTHRITIS									
CANCER									
DEPRESSION									
ANXIETY									
MENTAL ILLNESS									
ALCOHOLISM									
OTHER									

DIET / LIFESYLE:

DO YOU EXERCISE? Y / N

WHAT TYPE? _____ HOW OFTEN? _____

ARE YOU HAPPY WITH YOUR CURRENT WEIGHT? Y / N

DO YOU FOLLOW A SPECIAL DIET? Y / N

NAME OF DIET _____

HAVE YOU EXPERIENCED A RECENT CHANGE IN APPETITE? Y / N

PLEASE LIST ANY FOOD ALLERGIES OR INTOLERANCES _____

DO YOU FREQUENTLY USE ANY OF THE FOLLOWING?

- ASPRIN / TYLENOL / ADVIL LAXATIVES ANTACIDS DIET PILLS BIRTH CONTROL

PLEASE COMPLETE THE FOLLOWING TABLE:

	FORM	AMOUNT (per day)
WATER (bottled, tap, filtered, etc.)		
CAFFEINE (pop, coffee, tea, chocolate)		
TOBACCO		
RECREATIONAL DRUGS		
ALCOHOL		

ENVIRONMENT:

CURRENT OCCUPATION _____

KNOWN EXPOSURE TO TOXINS/ OTHER HAZARDS? _____

ARE THERE ANY SMOKERS IN THE HOUSE? Y / N

ARE THERE ANY PETS? Y / N PLEASE LIST _____

HOW IS THE HOUSE HEATED? _____

RECENT HOME RENOVATIONS? Y / N _____

HOW MANY HOURS OF TV / VIDEO DO YOU WATCH PER DAY? _____

HOW MANY HOURS ARE SPENT ON THE COMPUTER PER DAY? _____

HOW OFTEN DO YOU USE MICROWAVE? _____

IS THERE ANYTHING ELSE YOU THINK IS IMPORTANT WITH REGARDS TO YOUR HEALTH?
