Adult Patient Information

NOTE: THIS IS A CONFIDENTIAL MEDICAL RECORD AND WILL NOT BE RELEASED WITHOUT YOUR AUTHORIZATION.

Personal Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Home Phone: _____ Alternate Phone: _____

Email _____

Birth Date: _____ Sex: _____

Marital Status ❑ Married/Partner ❑ Single ❑ Separated ❑ Divorced ❑ Widowed

Social History

Occupation: _____ Employer: _____

Education Level: ❑ High School ❑ College ❑ Graduate ❑ Other:

Spiritual Practice: ❑ Yes ❑ No If Yes, please indicate which belief system: _____

Relaxation / Amusements / Hobbies:

_____

_____

Emergency Contact Information

Full Name: _____
Last *First* *M.I.*

Address: _____
Street Address *Apartment/Unit #*

_____
City *State* *ZIP Code*

Primary Phone: _____ Alternate Phone: _____

Relationship: _____

Physical Complaints

Please list your most important present health concerns in order of significance:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

List prescription (Rx) and non-prescription (Over the counter) medications you are taking, with dosage:

_____

_____

_____

_____

_____

_____

List Vitamins, minerals, herbs, homeopathic remedies presently taking, with dosage:

_____

_____

_____

_____

_____

_____

Past Hospitalizations, Surgeries: (List reason, type and your approximate age or year it occurred):

Approx. Date	Description of hospitalization / surgery

Other past injuries, accidents, serious illnesses?

_____

_____

_____

Exam History:	**Month / Year**	**Results**
Date of last physical exam?	_____	❑ **Normal** ❑ **Abnormal**
Last Cholesterol test?	_____	❑ **Normal** ❑ **Abnormal**
Women - Last PAP smear?	_____	❑ **Normal** ❑ **Abnormal**
Women - Last mammogram?	_____	❑ **Normal** ❑ **Abnormal**
Men - Last PSA blood test?	_____	❑ **Normal** ❑ **Abnormal**
Men - Last prostate exam?	_____	❑ **Normal** ❑ **Abnormal**

If abnormal, please provide details: _____

Are you allergic to any medications or supplements? ❑ Yes ❑ No If YES, list drug/supplement and reaction:

_____

Are you allergic to any foods or are there foods that don't agree with you? (List food and reaction)

_____

Any environmental allergies? _____

Are you currently being seen by other health practitioners? (Please list names & phone # if available.)

_____

_____

Diet History

How is your appetite? _____

Do you eat breakfast? ❑ Yes ❑ No

If Yes, please describe your typical breakfast? _____

Dietary Preference:
❑ Standard American ❑ Chicken / Turkey / Fish ❑ Vegetarian Only
❑ Reduced red meat ❑ Fish & Vegetarian ❑ Other: _____

I eat on average:

_____ Meals per day.

_____ Snacks per day.

❑ I graze all day.

Lifestyle History

How many hours sleep do you get on average per night? _____

Do you wake rested? ❑ Yes ❑ No

Do you have a hard time falling asleep? ❑ Yes ❑ No

Describe any other difficulties or patterns with your sleep:

How many hours do you work per week on average? _____

Rate your stress level (5 being most stressful):	1	2	3	4	5
Rate your energy level (5 being most energetic):	1	2	3	4	5

Rate your activity level: ❑ Sedentary ❑ Slightly ❑ Moderate ❑ Significant

How many times a week do you exercise and for how long? _____

Exercise activities: _____

Frequency of bowel movements _____

Typical color if known _____

Describe your stool: ❑ Loose ❑ Normal ❑ Hard ❑ Don't Know

Cigarette / Cigar / Chewing tobacco use history (include frequency, packs per day and ages you used):

Alcohol intake per day or week (list what type wine, beer, liquor)

Caffeinated beverage intake per day: _____

Any history of recreational drug use? If so, please specify. _____

Family Health History

Age and Disease or Cause of Death

Family Member	*Age*	*Disease / Cause of Death*
Mother		
Maternal Grandmother		
Maternal Grandfather		
Father		
Paternal Grandmother		
Paternal Grandfather		

Context of Care

Why did you choose to come to this clinic and what do you know about our approach?

What three expectations do you have from your visits to our clinic?

1. _____

2. _____

3. _____

What long-term expectations do you have from working with our clinic?

What expectations do you have of Dr. Lain as your physician?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle?

(Rate from 1 to 10, 10 being 100% committed)	1	2	3	4	5	6		8	9	10

List behaviors or lifestyle habits you currently engage in regularly that you believe support your health?

List behaviors or lifestyle habits 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 do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

What times of the day are you the weakest? Do you give permission to the person you listed above as someone who can call, text, or email you during this time of the day for accountability and support?

What do you LOVE to do?

What INSPIRES you?

What do you care most about in life?

General Information

Please tell us how you found out about our office or who you were referred by:

- ❑ Friend
- ❑ Internet
- ❑ Referral*
- ❑ Newspaper
- ❑ Other*****

*Please tell us who referred you so we can thank them! _____