ELIXIR
A WELLNESS COLLECTIVE

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ADULT INTAKE FORM

Legal Name:_____ Today's Date:___/___/_____

Preferred Name (If different from above): _____ Date of Birth:_____/___/_____

Address:_____ City/State/Zip:_____

Preferred Phone:_____Mobile / Home / Work (Circle one)

Email address:_____
We respect your privacy. We will only use your email to contact you about patient-related issues.

Emergency Contact:_____ Phone:_____Relationship:_____

Marital Status:_____Occupation:_____

How did you hear about our clinic? _____

Are you currently receiving care elsewhere? Y N If yes, please list where, from whom and for what concerns:

_____

_____

Primary Health Concerns / Diagnoses:

Concern Ex: Fever	*Since Ex: Last 2 Months*	*Frequency Ex: Daily*	*Severity 1-10 (10 worst)*
1._____	_____	_____	_____
2._____	_____	_____	_____
3._____	_____	_____	_____
4._____	_____	_____	_____
5._____	_____	_____	_____

Past medical history:
List any past health issues or diagnoses: serious accidents, severe injuries or illnesses, head injury, broken bones, dislocations, hospitalizations, surgeries, X-Rays, CT Scans, EEGs, and/or EKGs you have had (include date occurred):
1._____
2._____
3._____
4._____
5._____

Childhood illnesses: _____

Do you now or have you ever had:

Cancer	☐Past ☐Present ☐No
Diabetes	☐Past ☐Present ☐No
High blood pressure	☐Past ☐Present ☐No
Cardiovascular disease	☐Past ☐Present ☐No
Stroke	☐Past ☐Present ☐No
Glaucoma / Detached retina	☐Past ☐Present ☐No
Abnormal bleeding	☐Past ☐Present ☐No

Arthritis ☐Past ☐Present ☐No
Scoliosis ☐Past ☐Present ☐No
Other: _____

Are you allergic to any medicines? **Y N** If yes, please list them: _____
Are you allergic to any foods? **Y N** If yes, please list them: _____
Do you have any other allergies or sensitivities? **Y N** If yes, please list them: _____

Family history: Circle **G**randparent **P**arent or **S**ibling

Cancer	**G P S**	Diabetes	**G P S**	Allergies	**G P S**
Heart Disease	**G P S**	Autoimmune Disease	**G P S**	Obesity	**G P S**
Lung Disease	**G P S**	Mental Illness	**G P S**	Thyroid Illness	**G P S**

Any other relevant family history?_____

Social History: Circle **Y**es **N**o or **P**ast

Alcohol	**Y N P**	Pain Meds	**Y N P**	Steroids	**Y N P**
Smoking	**Y N P**	Antacids	**Y N P**	Recreational Drugs	**Y N P**
Laxatives	**Y N P**				

Exercise:

Type (What exercise do you do?)	*Frequency (How often?)*	*Duration (For how long?)*
_____	_____	_____
_____	_____	_____
_____	_____	_____

Diet:
Coffee (Oz/day)_____ Tea (Oz/day) _____ Alcohol (drinks/week)_____
Soda (Oz/day)_____ Water (Oz/day)_____

Please list what you had yesterday for:
Breakfast:_____
Lunch:_____
Dinner:_____
Snacks:_____

Stress Management:
Stress level (1-10; 10=highest) _____ Energy Level (1-10; 10=most) _____
Relaxation/Yoga/Tai Chi (#/week) _____
*Notes:*_____

Sleep:
Do you have difficulty falling asleep? **Y N**
Do you have difficulty staying asleep? **Y N**
How many hours of sleep do you get per night? _____
How many hours of sleep do you need per night? _____

Please list any specific goals for this consult*:*

_____

_____

How motivated are you to make lifestyle changes to benefit your health and your life?
(Circle a number) (Not motivated) 1 2 3 4 5 6 7 8 9 10 (Extremely motivated)

Environmental Exposures:
Have you had recurrent exposures to: (Check all that apply)
☐Chemical fertilizers ☐Pesticides ☐Herbicides ☐Mold ☐Paints ☐Wood preservatives ☐Heavy Metals
☐Chemical dyes ☐Cigarette Smoke ☐Gasoline ☐Hazardous Waste ☐Nail Salons ☐Hair Salons

Do you have mercury fillings in your teeth? **Y N P** If yes, how many? _____
Have you ever had a root canal? **Y N P** If yes, how many? _____
How often do you eat seafood? _____

What is the source of your drinking water? (tap, filtered, bottled) _____

Are you very sensitive to perfumes, essential oils, cigarette smoke, gasoline, etc? **Y N P**

Approximately how many rounds of antibiotics have you taken TOTAL in the past?
□0 □1-5 □6-10 □11-15 □16-20 □20 or more # in past 3 years?_____

Do your symptoms diminish or disappear when you are away from work or home? **Y N P**
If yes, which symptoms? _____

Current Drugs/Medications/Supplements:

Name	*Dosage Ex:300mg*	*Times taken/day*	*How Long Taken Ex:1year*
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____
5. _____	_____	_____	_____

Review of Systems*:*
For the following, please circle:
***Y** = A condition you <u>have now</u> **N** = Never had **P** = <u>Significant</u> problem in the past.*

HEAD
1. Headaches Y N P
2. Migraines Y N P

EARS
1. Ringing Y N P
2. Earaches Y N P
3. Dizziness or fainting spells Y N P
4. Impaired hearing Y N P
5. Vertigo Y N P

EYES
1. Dry / Itchy / Watery Y N P
2. Double Vision Y N P
3. Strain / Pain Y N P
4. Blurry Vision Y N P
5. Date of last eye exam _____

NOSE
1. Frequent colds Y N P
2. Congestion / Sinus trouble Y N P
3. Nose bleeds Y N P
4. Seasonal allergies Y N P

MOUTH/THROAT
1. Persistent Hoarseness Y N P
2. Bleeding gums Y N P
3. Frequent sore throat Y N P
4. Sore lips/tongue Y N P

SKIN
1. Rashes Y N P
2. Skin changes / problems Y N P
3. Change in nails or hair Y N P

CARDIOVASCULAR
1. Palpitations / Fluttering Y N P
2. Chest pain / Discomfort Y N P
3. Swelling of hands/feet/ankles Y N P
4. Blood clots Y N P
5. Stroke / Heart Attack Y N P
6. High blood pressure Y N P

VASCULAR
1. Anemia Y N P
2. Leg pain / cramps Y N P
3. Easy bleeding or bruising Y N P
4. Varicose veins Y N P
5. Numbness/Tingling Y N P

RESPIRATORY
1. Asthma / Wheezing Y N P
2. Difficult/heavy breathing Y N P
3. Shortness of breath Y N P
4. Spitting up blood Y N P
5. Chronic Infections Y N P

ENDOCRINE
1. Change in thirst Y N P
2. Change in appetite Y N P
3. Sensitivity to cold or heat Y N P
4. Tire easily Y N P
5. Crave salt Y N P
6. Crave sugar Y N P
7. Recent weight change Y N P
8. Mental fogginess Y N P

Continued on next page…

GASTROINTESTINAL

1. Chronic diarrhea Y N P
2. Ulcer Y N P
3. Jaundice Y N P
4. Heartburn Y N P
5. Trouble swallowing Y N P
6. Chronic constipation Y N P
7. Black stools Y N P
8. Hemorrhoids Y N P
9. Abdominal pain Y N P
10. Nausea / Vomiting Y N P
11. Frequent belching Y N P
12. Frequent gas Y N P
13. Frequent bloating Y N P
14. Gallstones Y N P
15. Mucous in stool Y N P
16. Blood in stool Y N P
17. Frequency of bowel movements (BMs) _____

NEUROLOGICAL

1. Seizures Y N P
2. Loss of memory Y N P
3. Numbness/tingling Y N P
4. Weakness or paralysis Y N P

URINARY

1. Incontinence Y N P
2. Kidney stones Y N P
3. Blood in urine Y N P
4. Frequent infections Y N P
5. Frequency at night Y N P
6. Painful urination Y N P
7. Increased frequency Y N P

FEMALE REPRODUCTIVE

1. Excessive hair growth Y N P
2. Pain with intercourse Y N P
3. Breast lump(s) Y N P
   Comments: _____
4. Fertility issues Y N P
5. Venereal disease Y N P
   If yes, which one(s):_____
6. Abnormal pap Y N P
7. Nipple discharge Y N P
8. Vaginal itching Y N P
9. Ovarian cysts Y N P
10. Uterine Fibroids Y N P
11. Reduced sex drive Y N P
12. Bleeding between periods Y N P
13. Menopausal symptoms Y N P
    Circle which apply: Hot flashes / Vaginal Dryness / Night Sweats / Heart Palpitations / Other:_____
14. PMS Y N P
    Circle which apply: Mood swings / Cramping / Acne / Fatigue / Breast tenderness / Other:_____
15. Hysterectomy: Y N If yes, what exactly was removed? _____
16. Age period began: _____
17. How many days does your period last? _____(Days you bleed)
18. How many days does your cycle last? _____(1st day of bleeding until the day before you begin again)
19. Is the flow heavy?: _____
20. Number of Pregnancies: _____
21. Number of Abortions or Miscarriages: _____

MUSCULOSKELETAL

1. Joint pain or stiffness Y N P
2. Swollen joints Y N P
3. Muscle spasm Y N P
5. Back pain / stiffness Y N P
6. Neck pain / stiffness Y N P

PSYCHIATRIC

1. Cry open/depressed Y N P
2. Anger or irritability Y N P
3. Anxiety/tension Y N P
4. Fear / Panic attacks Y N P
5. Considered suicide Y N P
6. History of Abuse Y N P I'm not sure

MALE REPRODUCTIVE

1. Hernias Y N P
2. Prostate issues Y N P
3. Difficulty starting urination Y N P
4. Venereal disease Y N P
   If yes, which one(s):_____
5. Testicular pain or lumps Y N P
6. Sexual difficulty Y N P
7. Discharge from penis Y N P
8. Fertility issues Y N P
9. Reduced sex drive Y N P

22. Number of Children: _____
23. 1st day of last menses: _____
24. Date of last pelvic exam: _____
25. Date of last mammogram: _____
26. Type of birth control used: _____
27. Is there any possibility you could be pregnant?:_____

☐ Are you seeking current treatment with Elixir for a motor vehicle or work related accident?

Date of Accident:_____

Diagnosis: _____

Do you have Medicare as a primary or secondary insurance?_____

To the best of my knowledge, the questions on this form have been accurately answered. I understand that providing incorrect information can be dangerous to my health. It is my responsibility to inform the clinic of any changes in my health/medical status. I also authorize the health care staff to perform the necessary services I may need.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN **DATE**

_____ _____

GUARDIAN NAME (IF APPLICABLE) **RELATIONSHIP TO PATIENT**