ADULT PATIENT PROFILE

Today's date: ______________

Last Name:_____________________________________ First Name:________________________________ MI: ____________

Nickname:______________________________________ Birthdate:__________________________ Age:_________________

Sex _____________________ Preferred pronouns (if any): ____

Mailing address: ____

Physical address (if different): ____

Phone: ____ Alternate: ____

Email address: ____

Emergency contact name: __________________________________ Relationship: __________________________________

Address: ____ Phone: _______________________________________

Occupation: ____

What is your current **living and relationship status**? ____

How did you hear about us? ____

PRESENT HEALTH CONCERNS: Please list most important health concerns and goals in their order of significance.

1.____

2.____

3.____

Please list any **allergies** (medication, food & environmental) & type of reaction: ____________________________________

____

MEDICATIONS & SUPPLEMENTS

Please list any supplements, prescription, and/or over-the-counter medications you are currently taking, with dosages:

____

____

____

LIFESTYLE

Please answer each question from 1 to 10, with 10 being the most	1	2	3	4	5	6	7	8	9	10
How satisfied are you with the health and aliveness of your body?										
How happy are you?										
How anxious, depressed or disturbed do you feel mentally or emotionally?										
How earnestly do you practice to bring about mental-emotional wellness?										
How earnestly you try to care for yourself through the ways you eat?										
How earnestly do you try to care for yourself by working out or exercise?										
How supported do you feel in your most intimate relationship(s)?										
How satisfying is your work or livelihood?										
How satisfying to your financial state?										
How understood and loved do you feel by others?										
How strong is your self-control?										
How kind are you to yourself?										
How satisfying was your childhood?										

Do you follow a specific diet (vegetarian, vegan, gluten-free, etc)? □ Y □ N ____________________________________

Do you have any concerns about your current relationship to foods? □ Y □ N ____________________________________

Do you exercise regularly? Type and frequency: ____

Do you drink alcohol: □ Y □ N Type & frequency: ____

Do you use marijuana? □ Y □ N Type & frequency: ____

Do you use tobacco products? □ Y □ N Type & frequency: ____

Do you use recreational drugs: □ Y □ N Type & frequency: ____

OTHER PROVIDERS ________**Initial** for authorization to collaborate / share information with specified providers

Do you have a Primary Care Physician (PCP)? Name of PCP: ____

Additional health care providers/counselors: ____

Date of last blood work: ___________ History of abnormal blood work? □ Y □ N Date: ________________________

Hospitalizations / surgeries / imaging:

Please list any surgeries, hospitalizations, injuries or serious illnesses you have experienced with approximate dates:

____

____

FAMILY HISTORY:

Mother (age / age of death): _______ Please describe general health: ____

Father (age / age of death): _______ Please describe general health: ____

Please list any relevant conditions (heart disease, high cholesterol, diabetes, obesity, addiction, mental illness, allergies, autoimmune conditions, etc.) of close family relatives (brothers, sisters, grandparents, children):

____

____

Were you breastfed as a child? □ Y □ N Delivery method at birth (check one): ___ Vaginally ___ Cesarean

What is your country of origin? ____ Are you adopted? □ Y □ N

Date of last tetanus booster (Td/Tdap): _____________ Do you receive seasonal flu vaccines? □ Y □ N

REVIEW OF SYSTEMS: Please circle the correct answer for the conditions listed below as they pertain to *your health*.

Y = current condition ***P = past condition***

General

Height ________ Weight ________ Weight 1 year ago ________ Max weight ________ When ________

Skin

Rashes	Y P	Eczema/hives	Y P	Itching	Y P
Acne/boils	Y P	Color changes	Y P	Lumps	Y P
Night sweats	Y P				

Head

Headache	Y P	Head injury	Y P

Eyes

Impaired vision	Y P	Glasses/contacts	Y P	Eye pain	Y P
Tearing/dryness	Y P	Double vision	Y P	Glaucoma	Y P
Cataracts	Y P				

Ears

Impaired hearing	Y P	Ringing	Y P	Earache	Y P
Dizziness	Y P	Frequent infections	Y P	Herpes	Y P

Nose & Sinuses

Frequent colds	Y P	Nose bleeds	Y P	Stuffiness	Y P
Hay fever	Y P	Sinus problems	Y P		

Mouth & Throat

Frequent colds	Y P	Nose bleeds	Y P	Gum problems	Y P
Hoarseness	Y P	Dental cavities	Y P		

Neck

Lumps	Y P	Swollen glands	Y P
Goiter	Y P	Pain or stiffness	Y P

Endocrine

Hypothyroid	Y P	Hyperthyroid	Y P	Diabetes	Y P
Excessive thirst	Y P	Excessive hunger	Y P	Heat/cold intolerance	Y P

Respiratory

Cough	Y P	Spitting up blood	Y P	Sputum	Y P
Wheezing	Y P	Asthma	Y P	Bronchitis	Y P
Pneumonia	Y P	Emphysema	Y P	Pleurisy	Y P
Difficult breathing	Y P	Pain on breathing	Y P	Tuberculosis	Y P
		Shortness of breath	Y P		

Cardiovascular

Heart disease	Y P	Angina	Y P	High blood pressure	Y P
Murmurs	Y P	Palpitations	Y P	Rheumatic fever	Y P
Swelling of ankles	Y P	Chest pain	Y P		

Peripheral vascular

Deep leg pain	Y P	Cold hands/feet	Y P	Varicose veins	Y P
Thrombophlebitis	Y P				

Blood

Anemia	Y P	Easy bleeding or bruising	Y P		

Gastrointestinal

Trouble swallowing	Y P	Heartburn	Y P	Change in thirst	Y P
Change in appetite	Y P	Nausea	Y P	Vomiting	Y P
Blood in stool	Y P	Belching/passing gas	Y P	Jaundice (yellow skin)	Y P
Liver disease	Y P	Gall bladder disease	Y P	Ulcer	Y P

Bowel movements: How often?____________________ Is this a change? □ Y □ N

Urinary

Pain on urination	Y P	Increased frequency	Y P	Frequency at night	Y P
Inability to hold urine	Y P	Frequent infections	Y P	Kidney stones	Y P

Female Reproductive

Age menses began: ____________ Average # of days: ____________ Length of cycle: ________

Bleeding between periods	Y P	Irregular cycles	Y P	Pain during intercourse	Y P
Painful menses	Y P	Excessive flow	Y P	Difficulty conceiving	Y P
Number of pregnancies	____________	Menopausal symptoms	Y P	Sexual difficulties	Y P
Number of live births	____________	Sexually transmitted infections	Y P	Are you sexually active?	Y P
Number of miscarriages	____________	Birth control	Y P	Type of birth control	______________
Number of abortions	____________	Lumps	Y P		
Breast pain or tenderness	Y P	Nipple discharge	Y P	Do you do self-breast exams?	□ Y □ N

Sexual orientation (check one): □ Heterosexual □ Bisexual □ Homosexual □ Other ______________________

Male Reproductive

Hernias	Y P	Testicular masses	Y P	Testicular pain	Y P
Are you sexually active?	Y P	Sexual difficulties	Y P	Prostate disease	Y P
Discharge	Y P	Sexually transmitted infections	Y P	Lesions or sores	Y P

Sexual orientation (check one): □ Heterosexual □ Bisexual □ Homosexual □ Other ______________________

Musculoskeletal

Joint pain or stiffness	Y P	Arthritis	Y P	Broken bones	Y P
Muscle pain/cramps	Y P	Osteoporosis	Y P	Osteopenia	Y P

Neurological

Fainting	Y P	Seizure	Y P	Paralysis	Y P
Muscle weakness	Y P	Loss of memory	Y P	Numbness/tingling	Y P

Emotional

Depression	Y P	Anxiety or nervousness	Y P	Disordered eating	Y P
Mood swings	Y P	Tension	Y P	Panic attacks	Y P
Sleep difficulties	Y P	Abuse	Y P	Memory/concentration changes	Y P

Thank you for taking the time to fill out this form.

We look forward to working with you in supporting your health goals!