Adult Intake Form

Patient name:	**Birthdate:** / /	**Age:**	**Date:** / /
Address:			
City:		**State/zip:**	
Home telephone: ( )		**Work telephone: ( )**	
Email address:			
Employer:			
Emergency contact:			
Relationship:			
Why have you made this appointment?			
Is this a new problem?			
Please describe your problem, including where it is, how severe it is, how long it has lasted.			
Medication allergies: If any, please list allergy and type of reaction.			
Your Primary Care Practitioner's name and phone number:			

Current medications

(including hormones, vitamins, herbs, nonprescription and prescription medications)

Drug/Supplement name	Dosage	Who prescribed

Drug/Supplement list: (continued)	Dosage	Prescriber

Operations and Hospitalizations

Reason	Date	Hospital

Date:
Printed name of patient:
Signature of patient: