Southern Maine Integrative Health Center
Adult Intake Form
DR. RONALD MOSIELLO

Patient Name:	Birthdate: / /	Age:	Date: / /
Address:			
City:	State/Zip:		
Home Telephone: ( )	Work Telephone: ( )		
Employer:	Cell phone: ( )		
Email Address:			
Emergency Contact:			
Relationship:			
Home Phone: ( )	Work Phone: ( )		
Why have you come to the office today?			

Injuries

INJURY	LOCATION ON HEAD/BODY	WHEN DID THIS OCCUR	SEVERITY OF PAIN 1-10 (10 WORST)

PATIENT'S NAME:	DATE:

Medication Allergies: If any, please list allergy and type of reaction.

Current Medications

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

Drug name	Dosage	Who prescribed	Drug name	Dosage	Who prescribed

Operations and Hospitalizations

Reason	Date	Hospital

Personal Profile

Height: _____ Weight: _____ Marital status: ___ married ___living with partner ___single ___ widowed ___divorced
Number of people in household:

PATIENT'S NAME:	**DATE:**
PERSONAL PROFILE CONT.	
Current or most recent job:	
Travel outside of the U.S.?	

Personal Past History of Illness

Major illness	**Yes** (DATE OF ONSET)	**No**	**Not sure**	**Physician's notes**
Asthma				
Pneumonia/lung disease				
Kidney infections/stones				
Tuberculosis				
Sexually transmitted disease				
HIV/aids				
Heart attack/problems				
Diabetes				
High blood pressure				
Stroke				
Rheumatic fever				
Blood clots in lungs or legs				
Eating disorders				
Collagen vascular disease (lupus)				
Chickenpox				
Cancer				
Reflux/hiatal hernia/ulcers				
Depression/anxiety				
Anemia				
Blood transfusions				
Seizures/convulsions/epilepsy				
Bowel problems				
Glaucoma				
Cataracts				

PATIENT'S NAME:	DATE:			
PERSONAL PAST HISTORY (CONT.)	**Yes (DATE OF ONSET)**	**NO**	**NOT SURE**	**Physician's notes**
Arthritis/joint pain/back problems				
Broken bones				
Jaundice/Liver disease				
Thyroid Disease				
Gallbladder Disease				
Headaches				
Other				

Family History

Mother- __living __deceased-cause:	Father- __living ___deceased cause:
Children: number living: Number Deceased: cause(s)/age(s):	

Illness	**Yes**	**Which relative(s) and age of onset**	**Physician's notes**
Diabetes			
Stroke			
Heart disease			
Blood clots in lungs or legs			
High blood pressure			
High cholesterol			
Osteoporosis (weak bones)			
Hepatitis			
HIV/AIDS			
Tuberculosis			
Birth defects			
Drinking or Drug problems			

PATIENT'S NAME:			**DATE:**
FAMILY HISTORY CONT.	YES	WHICH RELATIVE(S) AND DATE OF ONSET	PHYSICIAN'S NOTES
Breast cancer			
Colon cancer			
Ovarian cancer			
Uterine cancer			
Mental Illness/Depression			
Alzheimer's disease			
Other			

Social History

	Yes	**No**	**Physician's notes**
Ever smoked? Currently smoking?			
Alcohol:			
Recreational drug use?			
Seat belt use?			
Regular exercise:			
Health hazards at home and at work?			
Have you been sexually abused, threatened, or hurt by anyone?			

Review of Systems

Please check (x) if any of the following symptoms apply to you now or since childhood

	Now	**Past**	**Not sure**	**Physician's notes**
1. Constitutional				
Weight loss				
Weight gain				
Fever				
Fatigue				

PATIENT'S NAME:		**DATE:**		
REVIEW OF SYSTEMS CONT.	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
Change in height				
2. Eyes				
Double vision				
Spots before eyes				
Vision changes				
Glasses/contacts				
3. Ear, nose, and throat				
Earaches				
Ringing in ears				
Hearing problems				
Sinus problems				
Sore throat				
Mouth sores				
Dental problems				
4. Cardiovascular				
Painful breathing				
Chest pain or pressure				
Difficulty breathing on exertion				
Rapid or irregular heartbeat				
5. Respiratory				
Wheezing				
Spitting up blood				
Shortness of breath				
Chronic cough				
6. Gastrointestinal				
Frequent diarrhea				
Bloody stool				
Nausea/vomiting/indigestion				
Constipation				
Involuntary loss of gas or stool				
7. Genitourinary				
Blood in urine				
Pain with urination				

PATIENT'S NAME:			DATE:	
REVIEW OF SYSTEMS CONT	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
Strong urgency to urinate				
Frequent urination				
Incomplete emptying				
Involuntary/unintended urine loss				
Urine loss when coughing or lifting				
Abnormal bleeding				
Painful periods				
Premenstrual syndrome (PMS)				
Painful intercourse				
Fibroids				
Infertility				
DES exposure				
Abnormal Vaginal Discharge				
8. Musculoskeletal				
Muscle weakness				
Muscle or joint pain				
9. Skin				
Rash				
Sores				
Dry skin				
Moles				
10. Breasts				
Pain in breast				
Nipple discharge				
Lumps				
11. Neurologic				
Dizziness				
Seizures				
Numbness				
Trouble walking				
Severe memory problems				

PATIENT'S NAME:			DATE:	
REVIEW OF SYSTEMS CONT.	**NOW**	**PAST**	**NOT SURE**	**PHYSICIAN'S NOTES**
Frequent or severe Headaches				
12. Psychiatric				
Depression or frequent crying				
Severe anxiety				

13. Endocrine				
Hair loss				
Heat/cold intolerance				
Abnormal thirst				
Hot flashes				
14.Hematologic/Lymphatic				
Frequent bruises				
Cuts that do not stop bleeding				
Enlarged lymph nodes (glands)				
15. Allergies (food and other environmental)				
Signature of Patient:				
Date reviewed by physician with Patient:		**Physician Signature:**		