SEARLES WELLNESS • Mona Searles, ANP LAc
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Intake Form

Name_____Date_____

Address_____

City_____State_____Zip_____

Phone # Home_____Work_____Cell_____

Age_____Date of Birth_____Gender_____

Married___Separated___Partner___Divorced___Widowed____Single____Other_____

Live with: Spouse____ Partner____Parents____ Children____Friends____Alone_____

Education_____Occupation_____Hrs/wk_____Retired____

Employer_____E Mail Address_____

Work Address_____

Health Insurance name_____

Health Insurance address_____

Insurance phone #_____Policy ID#_____Group#_____

Policy holder's name_____Employer of Policy Holder_____

How did you hear about our clinic_____

Next of Kin or other to reach in an emergency_____Relationship_____

Phone_____Address_____

Are you currently receiving healthcare?_____

If yes, where and from whom? If no, when did you last receive health care and for what reason?_____

_____

Lifestyle Survey:

Do you follow any special diet; if Yes, what kind?

_____

Tobacco- smoke ___chew_____How much per day ?_____
Approx. date started_____Date quit_____

Alcohol- how many drinks/day? (1 drink=12oz beer/6oz wine/1 oz liquor):_____

Coffee (decaf or regular) tea (herbal/caffeinated) soft drinks (caffeinated/ diet) chocolate or other caffeine containing products_____ _____

Regular Exercise? How many hours per week?_____What type?

_____

Spiritual Practices?_____

Recreational Drugs?_____

Are you allergic or hypersensitive to any? Drugs, foods or environmental factors (perfume, pollen,
etc.)?_____

_____

Current Medications (include non-prescription & prescription medications):

Name	Dose	Name	Dose
_____		_____	
_____		_____	
_____		_____	
_____		_____	

List any Herbs/Vitamins/Supplements you are Currently Taking:

Name	Dose	Name	Dose

_____ _____

_____ _____

_____ _____

History of Surgery&/or Serious Injury:

Type of Occurrence	Date	Type of Occurrence	Date
_____		_____	
_____		_____	
_____		_____	

Personal Medical History:

Anemia	Yes	No	Gastrointestinal Disease	Yes	No
Diabetes	Yes	No	(Stomach) Ulcers	Yes	No
Thyroid Disorder	Yes	No	Gallbladder Disease	Yes	No
Arthritis	Yes	No	Liver Disease	Yes	No
Kidney Disease	Yes	No	Hepatitis	Yes	No
Bladder Infections	Yes	No	Respiratory Disorder	Yes	No
High Blood Pressure	Yes	No	Asthma	Yes	No
High Cholesterol	Yes	No	Pneumonia	Yes	No
Stroke/TIA	Yes	No	Sexual Transmitted Infection- type_____		
Headache ___migraine____tension _____cluster	Yes	No	Eating Disorder	Yes	No
Blood Transfusion	Yes	No	Chronic Fatigue Syndrome	Yes	No

Seasonal Allergies	Yes	No	Cancer – type_____	Yes	No
Skin Disorders	Yes	No	Depression/Anxiety	Yes	No
Type_____			Eye, Ear, Nose, Throat	Yes	No
Sexual Dysfunction	Yes	No	Dental Problems	Yes	No

Sleep Habits _____
Bowel Habits_____

Menstrual History (women)

Last menstruation_____ Cycle duration (days between period) _____ PMS_____
Period length _____ Flow quality (clots, bright, heavy, light)_____
Pregnancies_____ Live births_____ Miscarriages_____ Abortions____ Current Birth Control_____

Family History

Disease	*Relationship to You*	*Disease*	*Relationship to You*
Diabetes	_____	Alcoholism	_____
Heart Disease	_____	Thyroid Disorder	_____
Hypertension	_____	High Cholesterol	_____
Cancer (type)	_____	Bleeding Disorder	_____
	_____	Arthritis (type)	_____
Stroke	_____	Seizures	_____
Birth Defects	_____	Osteoporosis	_____
Mental Illness	_____	Other	_____

Specific Health Problem(s) You would like to Address Today:

_____
_____
_____
_____
_____