Health Matters
www.HealthMattersAZ.com

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Adult Intake Form

In order to provide you with the most appropriate treatment, please complete the following questionnaire.
All information is strictly confidential. PLEASE USE INK.

Name_____

Date of Birth _____

Address _____

City _____State_____ Zip _____

Phone ( ) _____ Email Address_____

Height _____Weight_____ Age _____ Gender: ☐ Male ☐ Female

Is it okay to leave brief messages (appointment reminders, lab results, or prescription information) on your voicemail?
☐ Yes ☐ No

Emergency Contact_____ Phone ( ) _____

Would you like to receive periodic wellness-related information from Heath Matters via email? ☐ Yes ☐ No

If you would like us to be able to speak with your significant other/family member regarding your personal care, please list his/her name:_____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Name of Spouse/Significant Other _____

If you have children, how many?_____

How did you hear about us (if referred, by whom)? _____

☐ Word of Mouth

☐ Internet Search

☐ Facebook/ Social Media

☐ Other

Do you have insurance? ☐ Yes ☐ No

What is the name of your insurance provider? _____

What is the name of your pharmacy and main cross streets or phone number?_____

_____

What health-related concerns prompted today's visit? (List in order of importance)

1. _____

2. _____

3. _____

4. _____

Who is your Primary Care Physician?_____

If you would like us to be your primary care provider, please indicate. ☐ Yes ☐ No

Please list your other health professionals (not to be contacted without your consent).

Name_____ Specialty_____

Name_____ Specialty_____

Name_____ Specialty_____

Drug allergies and reactions you have_____

Food allergies and reactions you have _____

PERSONAL AND FAMILY HEALTH HISTORY ✓ *Check any that apply*

Disease	Self	Parent	Grandparent	Child	Sibling
Alcohol/ Drug Abuse					
Allergies					
Anemia/Blood Disorder					
Autoimmune (lupus, rheumatoid)					
Cancer (please list type)					
Depression/Anxiety					
Diabetes					
Gastrointestinal Disease					
Heart Disease/ High blood pressure					
Overweight/Obesity					
Lung Disease					
Osteoporosis					
Stroke					
Surgeries/ Hospitalizations					
Thyroid Disease					
Other					

REVIEW OF SYMPTOMS *Circle all that apply*

DIGESTIVE	**FEMALE**	**MUSCULO-SKELETAL & NERVOUS SYSTEM**	**MOUTH AND THROAT**	**ENERGY/MOOD**
Diarrhea	Irregular cycle	Joint pain	Gingivitis	Fatigue Insomnia
Constipation	Hot flashes	Swelling	Sore throat	Depression
Passing Gas	Painful periods	Arthritis	Difficulty swallowing	Restlessness
Bloating	Heavy periods	Muscle pain	Hoarseness	Irritability
Abdominal Cramping	PMS	Stiffness/weakness	Cold sores/	Aggression
Heartburn	Low libido	Nerve pain	Canker sores	Anxiety
Belching	Vaginal dryness	Numbness	Post nasal drip	Mood Swings
Nausea	Infertility	Tremors	Tongue or throat pain	Thoughts of harming
Vomiting	Currently pregnant	Fainting	Loss of taste	self or others
Hemorrhoids	Vaginal Infections		Dental pain	Physical/mental abuse
	(candida, BV, STIs)		Swollen glands	
HEAD/ COGNITION	**MALE**	**EARS**	**EYES**	**NOSE**
Headaches/Migraines	Prostate disease	Ear drainage	Itchy/dry eyes	Congestion
Hair Loss	Testicular pain/	Ear aches or pain	Redness	Sneezing/runny nose
Dry Hair	concerns Hernia	Ringing	Eye pain	Frequent sinus
Vertigo	Low libido	Frequent Infections	Blurred vision	infections Dryness
Poor Focus/ADD	Infertility	Hearing loss	Recent vision changes	Nose bleeds
Weak memory	Infections or STIs			Allergies
Confusion	Erectile Dysfunction			Snoring or sleep apnea
KIDNEY/URINARY	**SKIN/NAILS**	**WEIGHT**	**LUNGS**	**HEART**
Frequent urination	Acne Moles/spots	Weight gain	Shortness of breath	Palpitations
Kidney infection/	Hives	Weight loss	Asthma	Chest pain/heaviness
stones	Sweating	Compulsive eating	Bronchitis	Murmur/arrhythmias
Bladder infections	Eczema	Bulimia	Wet Cough	High blood pressure
Pain with urination	Psoriasis	Anorexia	Dry Cough	Low blood pressure
Difficulty starting urine	Bruise easily	Lack of appetite	Chest congestion	Poor circulation
Urinary incontinence	Brittle nails	Water weight		(cold hands and feet)
	Skin cancer	Cravings		Edema

How many 8 oz glasses of water do you drink daily? _____Other beverages _____

Alcohol use? ☐ Yes ☐ No Frequency _____ Drug use? ☐ Yes ☐ No

Caffeine use? ☐ Yes ☐ No Frequency _____ Soda/candy/sugar use? ☐ Yes ☐ No

Tobacco use? ☐ Yes ☐ No Types _____ Daily usage _____ Number of years_____

Do you exercise? ☐ Yes ☐ No Frequency _____

Do you meditate/relax? ☐ Yes ☐ No Types _____ Frequency _____

What is your occupation? _____

How many hours do you work each week? _____

Rate your stress level (1 low – 10 high) _____ Current stressors?_____

Please list all current prescription medications, over the counter medications, herbs and dietary supplements you take:

Medication/ Supplement	Dosage	Purpose	How long have you taken it?	Prescribed by? Doctor's name or self	Side Effects

Mo/Yr of last medical exam_____

Last blood tests _____ (If you have a copy within the past year please bring it with you to your office visit.)

List any specialty labs that you have had tested (food allergy, cortisol, heavy metal, stool, etc.).

_____

_____

_____

Women: Mo/Yr of last:

Pap _____ Mammogram_____Menses _____

Bone Density _____ Skin exam _____Chiropractic Exam _____

Colonoscopy_____

Number of Pregnancies _____ Births _____ Miscarriages _____

Hysterectomy ☐ Yes ☐ No

Men: Mo/Yr of last:

Digital rectal exam _____ Skin exam _____Colonoscopy_____

Chiropractic Exam _____ Bone Density _____

TOXIC EXPOSURES

Did you grow up or work near any refinery, polluted area or live in a home with leaded paint? If so, what sort of pollution were you exposed to?

_____

Are you particularly sensitive to new carpeting, paints, perfumes, gasoline or other vapors?

_____

DIET

☐ Typical American Diet ☐ Paleo
☐ Vegan/ Vegetarian ☐ Healthy
☐ Could use improvement ☐ Skips meals

Do you eat breakfast every day? ☐ Yes ☐ No

What do you usually have for breakfast?_____

CONTEXT OF CARE REVIEW

What are your long-term health goals?

_____
_____
_____

To what extent are you open to changes in lifestyle and diet? ☐ Eager ☐ Receptive ☐ Resistant

What potential obstacles or self-destructive habits do you foresee holding you back from achieving your health goals?

_____
_____
_____

What supportive behavior, friend, or lifestyle habit do you foresee pushing you forward to achieving your health goals?

_____
_____
_____

What do you love to do?

_____
_____
_____

Thank you for taking the time to thoughtfully answer the above questions!
This is the first step toward better health!

Signed _____ Date _____

Health Matters

An Integrative Approach to Skin Care

Please take a moment to answer the questions below regarding any skin concerns.
Health Matters offers the highest quality skin care services and state of the art equipment.
We are here to help you achieve the skin of your dreams!

SKIN CARE

☐ Dull Skin
☐ Sun Damage
☐ Broken Capillaries
☐ Large Pores
☐ Uneven Skin Texture
☐ Freckles
☐ Unwanted Hair
☐ Fine Lines and Wrinkles
☐ Loss of Elasticity
☐ Acne Scars
☐ Uneven Skin
☐ Tone
☐ Redness
☐ Leg Veins
☐ Acne
☐ Oily Skin
☐ Dry Skin
☐ Rosacea
☐ Melasma
☐ Angiomas
☐ Excessive Sweating
☐ Other _____

Would you like to receive periodic aesthetic related information (discounts and specials) from Health Matters via email?

☐ Yes ☐ No

Would you like to schedule a free 20 minute skin consultation with our aesthetician?

☐ Yes ☐ No

Would you like our aesthetician to contact you to discuss any of the skin care concerns you listed above?

☐ Yes ☐ No

If yes, please select your preferred contact method.

Phone number (call or text) _____

Email address _____