



Date: _____

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Preferred Phone: _____

Cell Phone: _____

Okay to text? Y/N

Email: _____

Wellness Intake Form

If you could magically eliminate 5 health or wellness concerns what could they be?

1. _____

Comments: _____

2. _____

Comments: _____

3. _____

Comments: _____

4. _____

Comments: _____

5. _____

Comments: _____



STILLPOINT MEDICINE

Adult Health Questionnaire

Your answers to the following questions will help us to understand your medical history and the concerns you'd like to discuss **with** Dr. Tamara Taber. Please fill out this questionnaire. If you cannot answer some of the questions or feel uncomfortable answering them, leave them blank.

Patient Name: _____

Patient Date of Birth: _____ Today's Date: _____

What would you like to talk about today? _____

Medical History

Please list any medication allergies or reactions:

Please check to indicate if you ever had the following conditions:

- | | | |
|---|--|---------------------------------------|
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Heart attack | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Hepatitis |
| <input type="checkbox"/> Thyroid Disease | <input type="checkbox"/> Seizures | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Tuberculosis |
| <input type="checkbox"/> Congestive Heart Failure | <input type="checkbox"/> Coronary Artery Disease | <input type="checkbox"/> Eye problems |
| <input type="checkbox"/> Arrhythmia | <input type="checkbox"/> Cancer (Type): _____ | |
| <input type="checkbox"/> Sexual Transmitted Disease (Type): _____ | | |
| <input type="checkbox"/> Other, Please explain: _____ | | |
| _____ | | |
| _____ | | |
| _____ | | |

Please list any surgeries or hospital stays you have had and their approximate date / year.

Type of surgery / reason for hospitalization

Date

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

If you have any other medical problems or serious injuries that are not listed above, please describe them here:

When was your last physical?

Are you currently receiving care from any other doctors, chiropractors, or other health care professionals? If yes, we would like to know whom so that we can coordinate your care:

Provider's Name

Condition they are treating you for

_____	_____
_____	_____
_____	_____
_____	_____
_____	_____

Please note dates of you most recent immunizations:

Approximate Date

Tetanus	_____
Pneumonia	_____
Influenza	_____
Hepatitis B	_____
Other: _____	_____
Other: _____	_____

If you have had any of the following tests done, please note when the test or tests were done and what the results were, if known:

<i>Test</i>	<i>Approximate Date</i>	<i>Results</i>
Cholesterol	_____	_____
Pap smear/pelvic	_____	_____
Mammogram	_____	_____
Blood in stool	_____	_____

Family History

Other Comments:

Health Habits

Do you smoke or use any tobacco products? ___Quit ___Yes ___No

Number of cigarettes each day? _____

For how many years? _____

Other forms of tobacco used? _____

Do you drink alcohol? ___Quit ___Yes ___No

How much? _____

How often? _____

Have you ever felt that you should cut down on your drinking? ___Yes ___No

Have you regularly used other drugs? ___Yes ___No

If yes, are you still using them? ___Yes ___No

Sexual History

Are you sexually active? ___Yes ___No

With: ___Men ___Women. ___Both

Do you feel you are at risk for HIV/ AIDS? ___Yes ___No

Do you have children? ___Yes ___No

How many children do you have? _____

Do you use any form of birth control?

___Yes

___No

If yes, which type/ brand? _____

Women Only

Have you ever been pregnant?

___Yes

___No

How many times? _____

How many miscarriages? _____

How many children do you have living? _____

Do you have menstrual periods?

___Yes

___No

If no, at what age did they stop? _____

If yes, are your periods regular? _____

Sleep

Do you sleep well?

___Yes

___No

About how many hours do you sleep? _____

Do you wake up with pains or stiffness?

___Yes

___No

Do you wear a CPAP device?

___Yes

___No

Do you sleep on your back?

___Yes

___No

Do you sleep on your side?

___Yes

___No

Do you have dreams every night?

___Yes

___No

If yes, what do you dream about? _____

Are you a stomach sleeper?

___Yes

___No

What kind of pillow do you use?

Please describe your pillow size, firmness, softness, etc.

Describe your mattress. Does it dip or sag and does it offer proper support? _____

Have you ever had your posture checked? Yes No

If yes, when and what were your results? _____

What type of shoes do you typically wear everyday?

Other Comments:

Thank you,

Stillpoint Medicine

Dr. Tamara Taber