

MRN: _____
ADULT OPTIMAL LIFE INTAKE

Our ability to draw effective conclusions about your present state of health and how to improve it depends, to a significant extent, on your ability to respond thoughtfully and accurately to both these written questions and those posed by the clinician during your consultations. Health issues are usually influenced by many factors. Accurately assessing all the factors and comprehensively managing them is the best way to deal with these health challenges. Your careful consideration of each of the following questions will enhance your results.

Name: _____

Place of Birth: _____ (City or town & country if not US)

Occupation: _____

How did you hear about us: (e.g. word of mouth, advertising, direct mail, health insurance company, healthcare provider referral, other) _____

Do you have a Primary Care Physician (PCP)? _____

If you have a PCP, will you continue to see your PCP for your primary care issues? _____

Today's Date _____

1. With whom do you live? (Include children, parents, relatives, and/or friends. Please include ages.) Example: Wendy, age 7, sister

2. Please rank current and ongoing problems by priority and fill in the other boxes as completely as possible:

DESCRIBE PROBLEM	MILD/ MODERATE/ SEVERE	TREATMENT APPROACH	SUCCESS
Example: Post Nasal Drip	Moderate	Elimination Diet	Moderate
a.			
b.			
c.			
d.			

3.. Lab Question and Comment:

If you have questions regarding which lab tests will be covered by your health insurance, please call your insurance.

4. In general how do you rate your health? (please select from the following)

_____ Excellent _____ Very Good _____ Good _____ Fair _____ Poor

5. On average how much water do you drink? (In glasses, or ounces or cups etc.); What type of water do you mostly drink (well, city, distilled, reverse osmosis, spring etc.)

6. Besides your spouse, your kids, your parents and your job, what do you love to do, what is your passion, what is the one thing you enjoy the most to do?

7. On average what time do you go to sleep? What time do you wake up? Do you feel rested when you wake up?

8. On average how often in a week do you do physical activity (riding a bike, running, weight lifting etc.)?

8a. What type of physical activity do you do?

8b. How long are you usually doing this/these physical activities?

9. Do you feel like you have enough energy or are you usually tired?

10. How is your stress level (too much, okay, able to cope etc?)

11. Some people feel stress due to money situations. How is the money situation at home? (okay, very tight, not enough money for simple living etc.)

12. In your mouth how many root canals do you have?

13. Do you have mercury amalgam fillings? If so, how many?

14. Do odors affect you?