CUTLER INTEGRATIVE MEDICINE

ADULT INTAKE FORM

This form is completely confidential. Please submit by email, fax, mail, or in-person ***3 business days*** before your appointment.

PROFILE:

Name: _____ Gender: ☐ M ☐ F Age: _____

Today's Date: _____/_____/_____ (mm/dd/yyyy) Date of Birth: _____/_____/_____ (mm/dd/yyyy)

Address: _____

_____

Telephone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

Prefer Email Correspondence? ☐ Y ☐ N Email: _____

Occupation: _____ Employer: _____

Marital Status: ☐ Single ☐ Married ☐ Partnered ☐ Divorced ☐ Separated ☐ Widowed

Children / Ages: _____

_____

How did you hear about us? _____

May we give you appointment reminder calls? ☐ Y ☐ N (phone) _____-_____-_____

May we leave you phone messages? ☐ Y ☐ N (phone) _____-_____-_____ ☐ same as above

EMERGENCY CONTACT:

Name: Relationship:
Telephone: (Home) _____-_____-_____ (Cell) _____-_____-_____ (Work) _____-_____-_____

MEDICAL CONTACTS:

Name of Medical Doctor / Family Physician:

Telephone: _____-_____-_____

Date of last blood work: Date of last annual / physical exam:

List any other health care providers (name, specialty, telephone):

MEDICAL HISTORY:

List your health concerns in order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

Has any health concern recently changed or become worse? ☐ Y ☐ N

_____

_____

_____

What has your doctor (currently & previously) diagnosed you with?

_____

_____

_____

_____

_____

_____

_____

Please list all current medications (prescription or over-the-counter) and supplements (herbs, vitamins)

Name of Drug / Supplement	Used For	Date Started	Dose / Frequency

List past prescription medications: _____

_____

_____

List any known allergies (include drugs, food, environmental, chemical and etc.) and the reaction(s) from them.

_____

_____

_____

_____

Present Weight: _____ Weight one year ago: _____

Maximum weight and when: _____ Minimum weight (adult) and when: _____

Ideal weight: _____ Height: _____

Which of the following do you currently use?

Y = Current	N = Never	P = Past

Substance	Y	P	N	Per day	Type	Duration
Coffee	☐	☐	☐			
Soft Drinks (sodas)	☐	☐	☐			
Artificial Sweeteners	☐	☐	☐			
Tobacco	☐	☐	☐			
Alcohol	☐	☐	☐			
Recreational Drugs	☐	☐	☐			
Painkillers	☐	☐	☐			
Steroids	☐	☐	☐			
Laxatives	☐	☐	☐			
Analgesics	☐	☐	☐			
Antacids	☐	☐	☐			

List any traumas (mental, emotional, physical), injury, illness, surgery or hospitalizations:

Incident	Date	Long-term effects

Note when and why you have had each of the following:

X-Rays:		**MRI:**	
Ultrasounds:		**CAT Scans:**	
Tuberculosis Test:		**Last Dental Work:**	
HIV test:		**Last Eye Exam:**	

FOR MALES (*if applicable*):

Are you currently sexually active? ☐ Y ☐ N Have you been sexually active in the past? ☐ Y ☐ N
Do you use forms of contraception? ☐ Y ☐ N ☐ Sometimes Since: _____
Do you have regular prostate exams? ☐ Y ☐ N Any prostate exams abnormal? ☐ Y ☐ N If yes, results: _____
Do you have difficulty urinating completely? ☐ Y ☐ N _____
How many times do you get up from your sleep to go to the bathroom at night? _____
Do you have any sexual problems or concerns? ☐ Y ☐ N Explain: _____

FOR FEMALES (*if applicable*):

Are you pregnant? ☐ Y ☐ N ☐ Unknown Age at first period: _____

Date of last menstrual period: _____ Length of monthly cycle (days): _____ Length of bleeding (days): _____

Are you currently sexually active? ☐ Y ☐ N Have you been sexually active in the past? ☐ Y ☐ N

Do you use birth control? ☐ Y ☐ N ☐ Sometimes

Method: _____ Since: _____

Number of pregnancies: _____ Live births: _____ Miscarriages: _____ Abortions: _____

Date of last PAP test: _____ Any irregular PAP test? ☐ Y ☐ N Results: _____

Dexa (bone density) Scan results: _____

Mammography? ☐ Y ☐ N Results? _____ Do you perform self-breast exams monthly? ☐ Y ☐ N _____

Have you had any of the following concerning your breasts?

☐ Pain ☐ Lumps ☐ Infections ☐ Cysts ☐ Nipple discharge ☐ Other _____

Do you experience PMS? ☐ Y ☐ N

If yes, what are your symptoms of PMS?

☐ Cravings ☐ Bloating ☐ Breast tenderness ☐ Mood changes ☐ Other: _____

Are you menopausal? ☐ Y ☐ N Age of last period: _____

If yes, list any menopausal symptoms: _____

_____

Use of hormones? ☐ Y ☐ N

Type and dosage of hormones: _____

Do you experience vaginal infections? ☐ Never ☐ Rarely ☐ Frequently

Do you experience bladder infections? ☐ Never ☐ Rarely ☐ Frequently

Do you have any sexual problems or concerns? ☐ Y ☐ N Explain: _____

_____

CHILDHOOD ILLNESSES: (*check all that apply*)

☐ Chicken pox ☐ Measles ☐ Mumps ☐ Rubella ☐ Rheumatic fever

☐ Scarlet fever ☐ Tuberculosis ☐ Pertussis ☐ Other: _____

Where are you in the birth order? ☐ First ☐ Last ☐ Middle ☐ Only

VACCINATIONS: (*check all that apply*)

☐ DPT (diptheria, pertussis, tetanus) ☐ HIB (haemophilus influenza B) ☐ Small pox ☐ Varicella (chicken pox)

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Gardasil (HPV) ☐ Hepatitis A

☐ Hepatitis B ☐ Seasonal Flu shot ☐ Tetanus Booster ☐ RotaVirus

☐ Meningococcal ☐ Pneumococcal ☐ Unknown

Adverse reactions to any vaccines: ☐ Y ☐ N / If so, please explain _____

_____

How many times have you been treated with antibiotics? For what condition(s)?_____

Have you ever used probiotics after antibiotic use? ☐ Y ☐ N _____

FAMILY HISTORY:

Please indicate if you or any of your immediate family has had any of the following conditions:

Condition	Family Member(s)	Condition	Family Member(s)
Alcoholism / Drug abuse		Epilepsy	
Allergies / Hayfever		Heart disease	
Arthritis		High blood pressure	
Asthma / Emphysema		Kidney disease	
Auto-immune disease		Liver disease	
Bleeding disorder		Mental illness	
Cancer		Overweight / Obesity	
Diabetes		Stroke	
Digestive disorder		Thyroid problems	
Eating disorder		Other:	

☐ I don't know my family medical history (please explain why):

DIET / DIGESTION / LIFESTYLE / ENVIRONMENTAL:

Please record your diet for the last 3 days:

	Day 1	Day 2	Day 3
Breakfast			
Lunch			
Dinner			

Do you have dietary restrictions (religious, vegetarian, vegan)? ☐ Y ☐ N _____

How much water in ***ounces*** do you drink per day? _____ Type of water: _____

How much coffee do you drink per day? _____

How often do you have a bowel movement? _____

Do you tends towards? ☐ Constipation ☐ Diarrhea ☐ Both ☐ Other: _____

What is the color of your stool? _____ Any undigested food in stool? ☐ Y ☐ N

What is the shape of your stool? ☐ Well-formed ☐ Ribbon-like ☐ Pellets ☐ Other: _____

Y = Current	N = Never	P = Past

Good energy? ☐ Y ☐ N Rate your energy level: _____/10 (10 = best)

Fatigue: ☐ Y ☐ N ☐ P

If you have fatigue, when in morning, afternoon, evening is it the worst: _____

If you have fatigue, can you do what you need to during the day? ☐ Y ☐ N

Rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

Outlets/Activities to relieve stress: _____

_____

How often do you exercise: _____

What type of exercise: _____ For how long: _____

How many hours of sleep per night: _____

If waking up frequently, what is the reason: _____

Nightmares: ☐ Y ☐ N ☐ P Sleepwalk: ☐ Y ☐ N ☐ P

Wake Refreshed: ☐ Y ☐ N ☐ P Must nap during the day: ☐ Y ☐ N ☐ P

Grind teeth: ☐ Y ☐ N ☐ P Snore: ☐ Y ☐ N ☐ P

Enjoy job: ☐ Y ☐ N ☐ P Hours worked per week: _____

Highest education level: _____

Quality of significant relationship: _____

How do you spend your free time: _____

_____

History of sexual, mental/emotional, physical abuse: ☐ Y ☐ N _____

If so, at what age and by whom: _____

Active spiritual practice? ☐ Y ☐ N ☐ P

Spiritually satisfied? ☐ Y ☐ N ☐ P ☐ Not sure _____

If not active spiritually or spiritually satisfied, do you desire to explore and discover this area of health? ☐ Y ☐ N

What is your greatest health concern? _____

_____

How does it limit you the most? _____

_____

How committed are you towards making valuable changes? ☐ Little ☐ Moderate ☐ Very ☐ Don't Know

REVIEW OF SYMPTOMS:

Y = Current	N = Never	P = Past

SKIN								
Rash:	☐ Y	☐ N	☐ P		Color change:	☐ Y	☐ N	☐ P
Hives:	☐ Y	☐ N	☐ P		Lump:	☐ Y	☐ N	☐ P
Psoriasis / eczema	☐ Y	☐ N	☐ P		Itchy:	☐ Y	☐ N	☐ P
Dry:	☐ Y	☐ N	☐ P		Warts / moles:	☐ Y	☐ N	☐ P
Cancer:	☐ Y	☐ N	☐ P		Perspiration	☐ Y	☐ N	☐ P
HEAD								
Headache:	☐ Y	☐ N	☐ P		Migraine:	☐ Y	☐ N	☐ P
Dandruff:	☐ Y	☐ N	☐ P		Head injury:	☐ Y	☐ N	☐ P
Oily / dry hair:	☐ Y	☐ N	☐ P		Hair loss:	☐ Y	☐ N	☐ P
NOSE								
Frequent Colds:	☐ Y	☐ N	☐ P		Nosebleeds:	☐ Y	☐ N	☐ P
Congestion:	☐ Y	☐ N	☐ P		Post nasal drip:	☐ Y	☐ N	☐ P
Polyps:	☐ Y	☐ N	☐ P		Seasonal Allergies:	☐ Y	☐ N	☐ P
EYES								
Dry / Watery:	☐ Y	☐ N	☐ P		Blurry Vision:	☐ Y	☐ N	☐ P
Double Vision:	☐ Y	☐ N	☐ P		Cataracts:	☐ Y	☐ N	☐ P
Glaucoma:	☐ Y	☐ N	☐ P		Styes:	☐ Y	☐ N	☐ P
Strain:	☐ Y	☐ N	☐ P		Discharge:	☐ Y	☐ N	☐ P
Itchy:	☐ Y	☐ N	☐ P		Dark under eyelid	☐ Y	☐ N	☐ P
MOUTH / THROAT								
Canker sores:	☐ Y	☐ N	☐ P		Cold sores:	☐ Y	☐ N	☐ P
Sore throat:	☐ Y	☐ N	☐ P		Gum disease:	☐ Y	☐ N	☐ P

Dentures:	☐ Y	☐ N	☐ P		Cavities:	☐ Y	☐ N	☐ P
Loss of tastes:	☐ Y	☐ N	☐ P		Hoarsness:	☐ Y	☐ N	☐ P
NECK								
Stiffness:	☐ Y	☐ N	☐ P		Swollen glands:	☐ Y	☐ N	☐ P
Full movement:	☐ Y	☐ N	☐ P		Tension:	☐ Y	☐ N	☐ P
RESPIRATORY								
Cough:	☐ Y	☐ N	☐ P		Tuberculosis	☐ Y	☐ N	☐ P
Shortness of breath w/ exertion:	☐ Y	☐ N	☐ P		Bronchitis	☐ Y	☐ N	☐ P
Shortness of breath sitting:	☐ Y	☐ N	☐ P		Pneumonia:	☐ Y	☐ N	☐ P
Shortness of breath lying down:	☐ Y	☐ N	☐ P		Asthma	☐ Y	☐ N	☐ P
Wheezing:	☐ Y	☐ N	☐ P		Painful breathing	☐ Y	☐ N	☐ P
CARDIOVASCULAR								
High Blood Pressure:	☐ Y	☐ N	☐ P		Rheumatic Fever	☐ Y	☐ N	☐ P
Low Blood Pressure:	☐ Y	☐ N	☐ P		Murmurs	☐ Y	☐ N	☐ P
Arrhythmias:	☐ Y	☐ N	☐ P		Palpitations:	☐ Y	☐ N	☐ P
Edema:	☐ Y	☐ N	☐ P		Chest pain:	☐ Y	☐ N	☐ P
URINARY TRACT								
Incontinence:	☐ Y	☐ N	☐ P		Pain w/ urination	☐ Y	☐ N	☐ P
Frequent Infections:	☐ Y	☐ N	☐ P		Kidney Stones	☐ Y	☐ N	☐ P
Urgency	☐ Y	☐ N	☐ P		Discharge / blood	☐ Y	☐ N	☐ P
GASTROINTESTINAL								
Heartburn:	☐ Y	☐ N	☐ P		Parasites	☐ Y	☐ N	☐ P
Indigestion:	☐ Y	☐ N	☐ P		Blood in stool	☐ Y	☐ N	☐ P
Bloating:	☐ Y	☐ N	☐ P		Diarrhea	☐ Y	☐ N	☐ P
Nausea:	☐ Y	☐ N	☐ P		Constipation	☐ Y	☐ N	☐ P

Vomiting:	☐ Y	☐ N	☐ P		Liver disease:	☐ Y	☐ N	☐ P
Change in appetite:	☐ Y	☐ N	☐ P		Gall bladder disease	☐ Y	☐ N	☐ P
Pancreatitis:	☐ Y	☐ N	☐ P		Ulcer	☐ Y	☐ N	☐ P
MUSCULOSKELETAL								
Weakness:	☐ Y	☐ N	☐ P		Arthritis:	☐ Y	☐ N	☐ P
Stiffness:	☐ Y	☐ N	☐ P		Leg cramps:	☐ Y	☐ N	☐ P
Tremors:	☐ Y	☐ N	☐ P		Pain:	☐ Y	☐ N	☐ P
NERVOUS SYSTEM								
Paralysis:	☐ Y	☐ N	☐ P		Sciatica:	☐ Y	☐ N	☐ P
Tingling / numbness:	☐ Y	☐ N	☐ P		Carpal tunnel:	☐ Y	☐ N	☐ P
Seizures:	☐ Y	☐ N	☐ P		Fainting:	☐ Y	☐ N	☐ P
MENTAL / EMOTIONAL								
Depression:	☐ Y	☐ N	☐ P		Anger / Irritability	☐ Y	☐ N	☐ P
Suicidal:	☐ Y	☐ N	☐ P		High strung/ tense	☐ Y	☐ N	☐ P
Anxiety	☐ Y	☐ N	☐ P		Fear / Panic:	☐ Y	☐ N	☐ P
Eating disorder:	☐ Y	☐ N	☐ P		Psych hospitalization	☐ Y	☐ N	☐ P
PTSD	☐ Y	☐ N	☐ P		Brain Fog	☐ Y	☐ N	☐ P
MISCELLANEOUS								
Night Sweats:	☐ Y	☐ N	☐ P		Cold hands / feet	☐ Y	☐ N	☐ P
Spontaneous sweat	☐ Y	☐ N	☐ P		Phlegm	☐ Y	☐ N	☐ P
Easily awaken	☐ Y	☐ N	☐ P		Loss of voice	☐ Y	☐ N	☐ P
Foul breath	☐ Y	☐ N	☐ P		Thirsty	☐ Y	☐ N	☐ P
Bruise easily	☐ Y	☐ N	☐ P		Hemorrhoids	☐ Y	☐ N	☐ P
Excessive dreaming	☐ Y	☐ N	☐ P		Bitter tasting mouth	☐ Y	☐ N	☐ P
Brittle nail	☐ Y	☐ N	☐ P		Oversleep	☐ Y	☐ N	☐ P
Sigh easily	☐ Y	☐ N	☐ P		Ringing ears	☐ Y	☐ N	☐ P

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health, and in adhering to the therapeutic protocols?

_____

_____

_____

_____

What are your goals and expectations after your first new patient visit with Dr. Cutler?

_____

_____

_____

_____

Is there any other information that you feel is important that has not been covered?

_____

_____

_____

_____

Thank you very much for taking the time to complete this thorough form.
It will greatly assist in the formulation of an individualized protocol specific to your healthcare needs

CUTLER
INTEGRATIVE
MEDICINE

31350 Telegraph Rd. Suite 102 • Bingham Farms, MI 48025 • 248-663-0161 • Fax 248-594-9493
www.cutlerintegrativemedicine.com