FOOTHILLS
FAMILY MEDICINE
Your Natural Path to Health

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Return Office Call Intake Form

Name:___________________________________ Date of Birth:________________ Date:_____________

CURRENT PROBLEM LIST

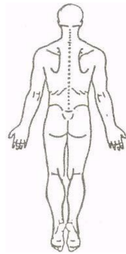
What are your most important health problems? List them in order of importance and time of onset

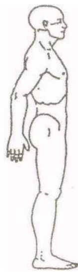
1.______________________________________ 4.____

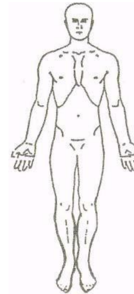
2.______________________________________ 5.____

3.______________________________________ 6.____

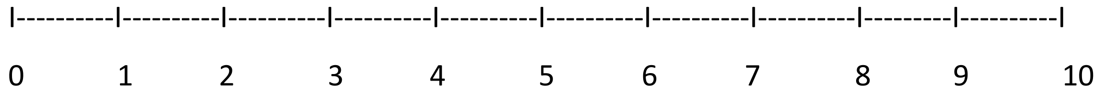
Please mark your areas of pain







Please indicate your CURRENT pain level on the chart below:



0 1 2 3 4 5 6 7 8 9 10

(No pain) (Moderate pain) (Worst Pain)

MEDICATION

Please list **all medications** (including over the counter) that you are currently taking and why. Please indicate dose and frequency.

________________________Start date__________ ________________________Start date____________

________________________Start date__________ ________________________Start date____________

________________________Start date__________ ________________________Start date____________

VITAMINS AND SUPPLEMENTS

Please list all vitamins and supplements you are taking and why (Please indicate dose and frequency)

________________________Start date__________ ________________________Start date___________

________________________Start date__________ ________________________Start date___________

________________________Start date__________ ________________________Start date___________