W. HAMLIN EMORY, M.D.
2080 Century Park East
Suite #1409
Los Angeles, CA 90067
Tel: (310)277-7711
FAX: (310) 277-7723

Please Print

Today's date:		Best contact number:		
Your last name:	First:	Middle:	Gender: ❑ Male ❑ Female	Marital status (circle one): Single / Mar / Div / Sep / Widowed / Partner
Name you like to be called:				
Street address:		Home phone: ( )		Cell phone: ( )
City:		State:	ZIP Code:	Email:

Birth date: / /	Age:	Mailing Address:

Occupation:	Employer:	Employer phone: ( )

If Student
❑ Part Time ❑ Full Time

PATIENT GUARDIAN/SPOUSE/EMERGENCY CONTACT

Parent / Guardian / Spouse/Emergency (circle one) Full Name:	Gender: ❑ MALE ❑ FEMALE	Address (if different):	Home phone: ( )
Is this person a patient here?	❑ Yes ❑ No		

FINANCIALLY RESPONSIBLE PARTY

Full Name:	Gender: ❑ MALE ❑ FEMALE	Address (if different):	Home phone: ( )
Is this person a patient here?	❑ Yes ❑ No		

I/We acknowledge that I/we have read, completely understand, and agree to the Office Policy.
I hereby request to become a patient of W. Hamlin Emory, M.D., a Medical Corporation.

Patient/Guardian Signature: Date:

Primary physician: _____ Phone Number: _____

Address: _____

If your primary residence is out of state, we require the name & contact information of a doctor in your home area with whom we can coordinate your ongoing care.

Please state your major concerns or difficulties: _____

_____

_____

_____

Some people's current concerns are different than those experienced in the past. Do you have a history of concerns or difficulties that are different from those you are experiencing now? _____

_____

_____

_____

At what age did you recognize the onset of your symptoms? _____

_____

Date of first consultation for these concerns: _____

Physicians with whom you have consulted (Please include dates and duration of treatment):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Psychotherapists with whom you have consulted (Please include dates and duration of treatment):

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

_____ _____

Which medical and/or psychological treatment(s) have been helpful? Please rate the effectiveness of each treatment.

(Rating -1 to + 3; adverse = -1, none = 0, slight = + 1, modest = + 2, marked = + 3)

_____

_____

_____

_____

In what ways have you coped with your difficulty?

_____

_____

_____

_____

Has your condition affected any of the following (Please circle and explain if yes)?

Family relationships: Yes / No _____

Function at work: Yes / No _____

Social relationships: Yes / No _____

Academic performance: Yes / No _____

Please Rate the following on a scale from 0 – 10
0 = lowest rating & 10 = highest; 7-9 is a normal range
**Rate yourself WITHOUT including any extreme or unexpected life stressors. We are primarily interested in your sense of physical well-being.*

Appetite ___ Libido ___
Calm ___ Mood ___
Energy ___ Sleep ___
Focus ___

How long does it take for you to achieve sleep?
0 – 15 min ___ 15 – 30 min ___ 30 – 60 min ___ Other _____

Once you achieve sleep, do you have difficulty remaining asleep? Yes ___ No ____
If so how many times do you wake? _____

Are you known to snore? Yes___ No___ Who reports your snoring? _____ To what extent do you snore? _____

Are you experiencing any physical pain?
Yes ___ No ___
If yes, please describe and Rate on a scale from 0 – 10.
_____

Are you craving any substances?
Yes ___ No ___

If yes, please describe and Rate on a scale from 0 – 10.
_____

_____

How frequent is your bowel elimination? _____
Have you had any difficulty eliminating (constipation, diarrhea, etc)?
_____

Are your thoughts faster, slower or the same rate as your speech? _____

Do you have allergies to any medication? (Circle one) Yes / No Please list: _____

List CURRENT medications (Please include medications prescribed by another physician, over-the-counter medications, nasal spray and vitamins/supplements.) * Please specify GENERIC or BRAND for all medications

Name of medication *(i.e., Omega 3-6-9)*	Strength *(i.e., 1000 mg)*	Daily Dosage *(i.e., 2 caps/day)*	Rate effectiveness (-1 to +3) *-1=adverse, 0=none, +1=slight, +2=modest, +3=marked*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

List PAST medications:

Name of medication *(i.e., Omega 3-6-9)*	Strength *(i.e., 1000 mg)*	Daily Dosage *(i.e., 2 caps/day)*	Effectiveness Rating (-1 to +3) *(-1=adverse, 0=none, +1=slight, +2=modest, +3=marked)*
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			

Please circle your answer to the questions below:

Do you have difficulty reading a map or following trip directions? Yes / No Handedness: Right / Left

Do you excessively procrastinate? Yes / No Are you disorganized? Yes / No

Are you an excessive worrier? Yes / No Are you forgetful? Yes / No

Do you experience irrational fears? Yes / No Do you feel inferior? Yes / No

Do you often feel irritable? Yes / No Do you often feel jumpy? Yes / No

How often are you having suicidal thoughts presently? Frequently Sometimes Rarely Never

How often have you had suicidal thoughts in the past? Frequently Sometimes Rarely Never

When: _____

How often do you think of harming others? Frequently Sometimes Rarely Never

In the past, how often have you had thoughts of harming others? Frequently Sometimes Rarely Never

Have you ever intentionally inflicted any harm upon yourself? Yes No Unsure

When: _____

Education:

For children, current grade: _____

For adults, highest level of education completed: _____

List college and graduate experiences/degrees and dates:

_____

_____

_____

_____

Employment:

Are you currently employed (Circle)? Yes / No

If yes, are (Check all that apply): _Part-Time _Full-Time _Temporary _Permanent _Self-Employed

How did you learn about the work we are doing?

_____

_____

Additional Comments:

_____

_____

_____

_____

Patient Signature: _____ Date: _____

By signing above I indicate that I have read and understood the office policies and procedures and that the information contained in these intake forms is correct to the best of my knowledge.

Family History

	Grandmother		Grandfather		Father	Mother	Brother		Sister		Spouse/	Children	
	Paternal	Maternal	Paternal	Maternal			1	2	1	2	Partner	1	2
Age (if living)													
Age Deceased													
Health (G) Good (F) Fair (P) Poor													
Alcohol Abuse													
Arthritis													
Asthma, Hives, or Hay Fever													
Blood Disease													
Cancer													
Drug Abuse													
Epilepsy													
Heart Trouble													
High Blood Pressure													
Mental Illness													
Stroke													
Tuberculosis													
Neurological Disorder													

Personal History

Have you ever had...	No	Yes	Have you ever had…	No	Yes	Have you ever had…	No	Yes
_Arthritis _Rheumatism			Anemia			Broken Bones		
_Bone Disease			Cancer			Recurrent Dislocations		
_Bursitis _Joint Disease _Sciatica			Diabetes _Type I _ Type II			_Concussion _Head Injury		
Diphtheria			Seizures or Epilepsy			Food Poisoning		
Pleuritis			Frequent: _Colds _Sore Throats			Chemical Poisoning		
Pneumonia			Frequent: _Infections _Boils			Chronic Fatigue Syndrome		
_Neuritis _Neuralgia			_Hay Fever _Asthma			Latex Sensitivity		
Scarlet Fever			_Hives _Eczema			Any other Disease:		
Smallpox			_High _ Low Blood Pressure			Explain:		
_Rheumatic Fever _Heart Disease			Migraine Headaches					
_Polio _ Meningitis			Tinnitus (Ringing in ears)					
_Gonorrhea _Syphilis _HIV			Tuberculosis					

Allergies

Are you allergic to...	No	Yes	Are you allergic to…	No	Yes	Are you allergic to…	No	Yes
_ Penicillin _ Sulfa Drugs			Any other Drugs			Any Foods		
_ Aspirin _ Codeine _ Morphine			Explain:			Explain:		
_ Antibiotics			Iodine or Radiologic Dye					
_Tetanus _Antitoxin			Adhesive Tape			_Nail Polish _Cosmetics		

Surgery

Have you had removed…	No	Yes	Have you had removed…	No	Yes	Have you…	No	Yes
Tonsils			_Ovary _Ovaries			Had a hernia repaired		
Appendix			Hemorrhoids			Had a Transfusion _Blood _ Plasma		
Gall Bladder			Have you been hospitalized			Had any other operations		
Uterus			Explain:			Explain		

X-Rays

Ever had X-Rays of…	No	Yes	Ever had…	No	Yes	Have you had other tests?
Chest			Colonoscopy			Explain:

_Stomach _Colon			Sigmoidoscopy			
Gall Bladder			Barium Enema			
_Extremities _Back			Mammogram			

REVIEW OF SYSTEMS

Date of Birth: Height: Weight:

Do you now have or have you ever had…	No	Yes	Do you now have or have you ever had…	No	Yes
_ Eye Disease _ Eye Injury _ Impaired Sight			Alopecia (Hair Loss)		
Tunnel Vision			Kidney: _Disease _Stones		
_ Ear Disease _ Ear Injury _ Impaired Hearing			Bladder Disease		
Any trouble with: _ Nose _ Sinuses _ Mouth _ Throat			Blood in Urine		
Fainting Spells			_ Protein _ Sugar _ Pus _ Other in Urine		
Convulsion(s)			Difficulty with Urination		
_ Memory Loss _ Confusion / Blurred Thinking			Narrowed Urinary Stream		
Episodes of Lapses in Time or Memory			Abnormal Thirst		
Dizziness			Prostate Trouble		
Dry Mouth			_ Stomach Trouble _ Ulcer		
Enlarged Glands			Indigestion		
Thyroid: _ Overactive _ Underactive _ Enlarged			_ Gas _Belching		
Enlarged Goiter			Appendicitis		
Cough: _Frequent _ Chronic			_Liver Disease _Gall Bladder Disease		
_ Chest Pain _ Angina Pectoris			_ Colitis _Other Bowel Disease		
Spitting up Blood			_ Hemorrhoids _Rectal Bleeding		
Night Sweats			Black Tarry Stools		
Episodes of Snoring			_ Any Change in Bowel Action _Stools		
Shortness of Breath: _ Upon Exertion _ At Night			_ Constipation _ Diarrhea		
_ Fluttering Heart _Palpitations			_ Parasites _ Worms		
Swelling of: _ Hands _ Feet _ Ankles			_ Any Change in Appetite or Eating Habits		
Frequently Cold Hands / Fingers			Explain:		
Paralysis			Change in Weight: ___ lbs lost ___lbs gained		
Restless Legs			Nausea / Vomiting		
Burning Sensation in Feet			Extreme: _ Tiredness _Weakness		
Headaches : _ Frequent _ Severe			Erectile Dysfunction		
Varicose Veins			Nipple Discharge		
Skin Disease			Other:		

Immunization – EKG

Have you had…	No	Yes		No	Yes
Smallpox Vaccination (Within last 7 years)			Polio Shots (Within last 2 years)		
Tetanus Shot (Not Antitoxin)			Influenza		
Hepatitis Vaccination			Electrocardiogram When:		
MMR (Measles, Mumps, Rubella)			Other:		

Females Only

Menstrual History…	No	Yes		No	Yes
Age of Onset:			Are you Regular: _ Heavy _ Medium _ Light		
Usual Duration of Period ___ Days			Do you have: _Tension _Depression Prior to Period		
Cycle (Start to Start) ___ Days			Do you have: _Cramps _ Pain with Period		
Date of Last Period:			Do you have Hot Flashes		
Pregnancies	No	Yes			
Children Born Alive (How many ___)			Still Born (How many ___)		
Cesarean Sections (How many ___)			Miscarriages (How many ___)		
Premature (How many ___)			Any complications:		
			Explain:		

Social History

Do you…	No	Yes	Have often do you use…	Never	Occ.	Freq	Daily
Exercise: If so, how often:			Laxatives				
What type of exercise:			_Vitamins _ Supplements				
Do you use Tobacco:			_Aspirin _ Ibuprofen _Aleve				
_Cigarettes (___ packs per day)			_Tranquilizers _Sleeping pills				
_Cigars _Pipe _Chewing Tobacco _ Snuff			Cortisone				
Do you use Other Drugs:			Alcoholic Beverages				

Do you chew gum: (___ pieces/day or ___ packs/day)			_ Diet Soda _ Energy Drinks				
Explain:			Explain:				

Nutritional Habits

Please list the foods consumed at each meal on an average day

Breakfast or 1st meal:
Snack:
Lunch or 2nd meal:
Snack:
Dinner or 3rd meal:
Other:

Childhood Developmental Milestones

Parents, please list the age at which your child reached the following developmental milestones:

Physical	Social & Emotional	Intellectual	Language
Sit up on own _____	Developed signs of enjoyment _____	Aware of physical sensations _____	Cries vigorously _____
Crawl _____	Apprehensive towards strangers _____	Developed interest in surroundings _____	Attentive to your voice _____
Walk _____	Emotionally dependent on a familiar adult _____	Makes 2 – 3 word sentences _____	Use of 2 syllable words (ex: Mama) _____
Feeds self _____	Imitates domestic activities _____	Relates present and past activities _____	Vocalized to attract attention _____
Dresses self _____	Aware of physical needs _____	Shows interest in pictures _____	Responded to simple instructions _____
Build a tower of cubes _____	Begin imaginary play _____	Accurately counts to 20 _____	Able to communicate needs _____
Potty trained during the daytime _____	Plays cooperatively with other children _____	Able to write own name _____	Able to accumulate new words rapidly _____
Fully potty trained _____	Able to cope with personal needs _____	Able to accurately state age _____	Developed sense of time _____
Ties own shoes _____	Chooses own friends _____	Draws with precision and detail _____	Talks fluently and with confidence _____