DelCare Health Solutions, LLC
Medical Intake Form

Please complete all of the following as accurately as possible:

Name _____ Age _____ Birthdate _____ Sex _____

Address _____ City _____ Zip _____

Phone (H) _____ _____ (W) _____ _____

Occupation _____ Full Time / Part Time

Employer _____ Education Level _____

Married _____ Separated _____ Divorced _____ Widow _____ Single _____ Other _____

Children (ages) _____

How did you hear about us? _____

Are you familiar with Homeopathy? _____

What is the Level of Your Health? Excellent _____ Good _____ Fair _____ Poor _____

Please list your most concerning health care problems at this time (in order of importance to you):

1. _____
2. _____
3. _____
4. _____

When did your chief problem or illness begin? _____

What do you think may have caused your chief complaint?

_____