CLOVER INTAKE SHEET

Name: _____ Date: _____

Date of Birth: _____

Medical Problem:

1) Depression	**Yes**	**No**
2) Anxiety	**Yes**	**No**
3) Alcohol Abuse	**Yes**	**No**
4) Drug Abuse	**Yes**	**No**
5) Rheumatoid Arthritis	**Yes**	**No**
6) Asthma/COPD	**Yes**	**No**
7) Diabetes	**Yes**	**No-**
8) Last Eye Exam	**Date _____**	
9) Last Mammogram	**Date _____**	
10) Last Colonoscopy	**Date _____**	
11) Fall in last one year	**Yes**	**No**
12) Urinary Incontinence	**Yes**	**No**
13) Heart Failure	**Yes**	**No**
14) Neurological Diseases/Seizure	**Yes**	**No**
15) Immunological Problem	**Yes**	**No**