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ADULT INTAKE FORM

Please take the time to fill in the following information. It provides a basis for further questions during your visit and helps provide insight into your health. All information is for office use only and is strictly confidential, and would only be release with written consent.

Patient Information

Full Name: _____ Date of Birth: _____ Age:_____ Gender: _____
Address: _____ City: _____Postal Code:_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ May we leave messages regarding your visits ? On what number? _____
Occupation: _____ Full or Part-time? _____ Shift work? _____
Marital Status: single married common-law separated divorced other: _____
Children: yes no If yes, please list ages: _____
How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.
_____

Emergency Contact

Full name: _____
Relationship to Patient: _____
Home Phone/Cell: _____

Please List Other Health Care Providers

1. _____ Specialty: _____ Phone: _____
2. _____ Specialty: _____ Phone: _____
3. _____ Specialty: _____ Phone: _____

Current Health Concerns

What are your health concerns, in order of importance to you?
1. _____ 2. _____
3. _____ 4. _____
How do you rate your general state of health? __ poor __fair __ good __ very good __ excellent
Comments: _____

Medical History

Current and past diagnosed conditions (incl. year diagnosed)
_____
_____
_____

Current or past illnesses, accidents, or hospitalizations (incl. year):
_____
_____
_____

Allergies or sensitivities (food, drugs, environmental, pets, etc.)
_____
_____
_____
_____

How many times have you been treated with antibiotics? _____
Do you get regular screening tests (PAP, blood, etc.)? _____
Date of last screening physical: _____
Are you currently pregnant: _____ Due Date: _____
Are you currently breast feeding: _____

Medications and Supplements

List all CURRENT prescribed medications (incl. birth control):
Drug name: _____ Dosage: _____ Length taken: _____
Drug name: _____ Dosage: _____ Length taken: _____
Drug name: _____ Dosage: _____ Length taken: _____
Drug name: _____ Dosage: _____ Length taken: _____
List all CURRENT vitamins, minerals, herbs and supplements: _____
_____
List all PAST prescribed medications that you've taken for longer than 3 months: _____
_____
List any prescribed medication or supplement that you've had an adverse reaction to in the past. Indicated name, date, and reaction:
_____
_____

Lifestyle History

Please list what you ate in the past 24 hrs:

Breakfast: _____

Snack: _____

Lunch: _____

Snack: _____

Dinner: _____

Snack: _____

Do you avoid any foods and why? _____

Do you exercise? _____

If yes, how often? _____ times per week

… how long? _____ minutes per workout

… what forms? _____

How much water do you drink? _____ glasses per day

Describe your appetite: _____

How would you rate your energy level (rate from 1-10, 10= Best) _____

How many hours of sleep do you get a night? _____ Do you wake rested? _____ Do you have difficulty falling asleep? _____

Do you have difficulty staying asleep? _____

What are your sleep patterns? (Incl, usual times of sleep, wake, naps, etc.):

_____

_____

What is your height? _____ Current weight? _____ Max weight? _____ Min weight? _____ Weight one year ago? _____

Have you lost any weight recently? _____ If yes, how many pounds? _____

Indicate whether you use or are exposed to the following (and if so, how much/how often)

Tobacco smoke: _____

Coffee: _____

Tea: _____

Pop: _____

Alcohol: _____

Recreational drugs: _____

Excess stress: _____

Chemicals: _____

Family History: please indicate any health conditions that have affected members of your family:

Relative	Age if Alive	Age at Death	Health Conditions
Mother			
Father			
Sibling			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Clarification of Goals:

What are 3 goals you want to achieve from the first visit?

1. _____ 2. _____ 3. _____

What long term expectations do you have from working with me as your Naturopathic Doctor? _____

_____

What behaviours/activities do you currently engage in that support your health? _____

_____

What behaviours/activities do you currently engage in that hinder your health? _____

_____

What is your present level of commitment to learn and implement healthy changes that will improve your health and well-being (Rate 1-10) _____

If below an 8, what will it take to increase your level of commitment? _____

What potential obstacles do you foresee in addressing factors that are undermining your health, and would make it difficult to follow a treatment plan?

_____

Who do you know that will sincerely support you with the beneficial lifestyle changes you will be making?

_____

What do you love to do? _____

Review of Systems: please check **Y** if you have the symptom now, and **P** if you you've had the symptom in the past.

SKIN	**Y**	**P**
Rash		
Hives		
Acne		
Boils		
Eczema/Atopic Dermatitis		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other:		

HEAD	**Y**	**P**
Tension headaches		
Migraine headaches		
Head injury		
Dizziness		
Other:		

EYES	**Y**	**P**
Impaired vision		
Use of corrective lenses		
Eye pain		
Tearing		
Dryness		
Double vision		
Cataracts		
Glaucoma		
Light sensitive		
Itching		
Redness		
Discharge		
Blind spot		
Other		

EARS	**Y**	**P**
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

MOUTH & THROAT	**Y**	**P**
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Bad breath		
Other:		

NECK	**Y**	**P**
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other:		

RESPIRATORY	**Y**	**P**
Cough		
Sputum		
Spitting with blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Emphysema		
Sleep apnea		
Difficulty breathing		
Pain on breathing		
Shortness of breath when lying		
Positive tuberculosis test		
Last TB test		
Last chest x-ray		
Other		

BREASTS	**Y**	**P**
Do you perform self breast exams?		
Lumps		
Pain/Tenderness		
Nipple discharge		
Last mammogram		
Other:		

CARDIOVASCULAR	Y	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitations, fluttering		
Elevated cholesterol		
Other:		

GASTROINTESTINAL	Y	P
Heartburn		
Change in appetite		
Nausea		
Vomiting		
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hernia		
Last colonoscopy		
Other		

ENDOCRINE	Y	P
Heat or cold intolerance		
Thyroid condition		
Excessive thirst		
Excessive hunger		
Excessive urination		
Excessive sweating		
Diabetes		
Hypoglycemia		
Hormone therapy		
Other		

URINARY	Y	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

MALE REPRODUCTIVE	Y	P
Hernia		
Testicular masses		
Testicular pain		
Impotence		
Premature ejaculation		
Veneral disease (STI, STD)		
Discharge		
Sexually active		
Last prostate exam:		
Last PSA level:		
Other		

FEMALE REPRODUCTIVE	Y	P
Age of first menses:		
Last menstrual period:		
Length of cycle:		
Number of days of menses:		
Bleeding/spotting between periods		
Irregular cycles		
Pain during intercourse		
Painful menses		
Excessive flow		
PMS symptoms		
Number of pregnancies		
Number of live births		
Number of miscarriages		
Number of abortions		
Difficulty conceiving		
Low libido		
Vaginal discharge		
Vaginal itching		
Sexually active		
Menopause		
Age of onset:		
Hormone therapy		
Last gynecological exam:		
Last PAP smear:		
Other:		

MUSCULOSKELETAL	Y	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other:		

PERIPHERAL VASCULAR	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Deep vein thrombosis		
Leg cramps		
Exretmity numbness		
Extremity swelling		
Extremity ulcers		
Other		

NEUROLOGIC	Y	P
Fainting		
Seizure/Convulsions		
Paralysis		
Muscle Weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of Balance		
Speech problems		
Other		

BLOOD/LYMPHATIC	Y	P
Anemia		
Easy bleeding/bruising		
Past transfusion		
Lymph node swelling		
Other:		

EMOTIONAL	Y	P
Depression		
Anger		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual Difficulties		
Drug abuse		
Psychiatric care		
Psychological counseling		
Other		