Adult Naturopathic Intake

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PLEASE COMPLETE THIS FORM AND BRING THE COMPLETED FORM TO YOUR INITIAL CONSULTATION

(Please print clearly)

Name _____ Date _____

Date of birth _____ (M/D/Y) Age:_____

Address:_____ Apt/unit #_____

City _____ Province _____ Postal Code_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____ C ell:_____

May we leave messages relating to your visits? Y / N Which Phone Number_____

Emergency contact: Name: _____

Phone number(s): (_____)_____ Or (_____)_____ Relation: _____

How did you hear about our Clinic? Please check one of the following:

- ❑ A patient of the office (please provide name) _____
- ❑ My medical doctor/Specialist (please provide name) _____
- ❑ Other Health Care Provider (please provide name):_____
- ❑ Advertising (newspaper, brochure)
- ❑ Social Media (Facebook, Twitter etc.)
- ❑ Website
- ❑ Staff
- ❑ Information Session/Workshop
- ❑ Other: _____

How would you identify your gender identity (please check all appropriate boxes):

☐ Female ☐ Male ☐ Transgender _____ ☐ Alternative: _____ ☐ Prefer not to answer

Other health care providers you are seeing:

Name:_____ Name:_____ Name: _____

Specialty:_____ Specialty:_____ Specialty:_____

Ph (_____)_____ Ph (_____)_____ Ph (_____)_____

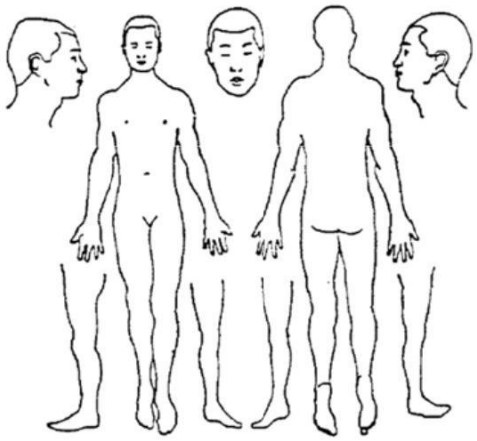
Date of last visit: _____ Date of last visit: _____ Date of last visit: _____

Have you ever consulted (Please check all that apply):

☐ Naturopathic doctor ☐ Acupuncturist ☐ Nutritionist ☐ Counselor

Health Goals

What are your health concerns and goals, in or der of importance to you:

Please list most important concerns and goals in their order of significance:	Previous diagnoses?	**Indicate Painful or distressed areas:** 
1.		
2.		
3.		
4.		
5.		

Are you currently pregnant? Yes No (Please circle one) Due date: _____

Are you currently lactating? Yes No (Please circle one)

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Do you have any allergies (medicines, environmental, etc.)?

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Please list all <u>current</u> medications & natural health products (prescription, over-the- counter, vitamins)

_____

_____

_____

Please list <u>past</u> prescription medications/natural health products:

_____

_____

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers Y N P

Laxatives Y N P Antacids Y N P Diet pills Y N P

Birth control Y N P Type (please circle) Pills / Implants / Injections

Antibiotics Y N P Approximate number of prescriptions: _____

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often_____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A

☐ Tetanus booster; when? ☐ "Flu" ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox

Other _____

Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N Last time you had blood work done_____

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you, Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current.

	Yes (✓)	Relation Please circle	Dates Resolved		Yes (✓)	Relation Please circle	Dates Resolved
Alcoholism/Drug addiction		Self F M S G C	Past Current	High Blood pressure		Self F M S G C	Past Current
Allergies		Self F M S G C	Past Current	Heart Disease		Self F M S G C	Past Current
Anemia		Self F M S G C	Past Current	Hepatitis		Self F M S G C	Past Current
Arthritis		Self F M S G C	Past Current	Headaches		Self F M S G C	Past Current
Asthma		Self F M S G C	Past Current	Kidney disease		Self F M S G C	Past Current
Cancer		Self F M S G C	Past Current	Stroke		Self F M S G C	Past Current
Diabetes		Self F M S G C	Past Current	Tuberculosis		Self F M S G C	Past Current
Eczema		Self F M S G C	Past Current	Osteoporosis		Self F M S G C	Past Current
Epilepsy		Self F M S G C	Past Current	Others:		Self F M S G C	Past Current
Depression/other Mental Illness		Self F M S G C	Past Current				

Diet

Do you have any food allergies or intolerances? Please list.

1) _____ 4) _____
2) _____ 5) _____
3) _____ 6) _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

Environment

Occupation _____

Hobbies_____

Do you exercise regularly? Y / N

What do you do for exercise, how much, how often?

_____

_____

_____

Are you exposed to significant tobacco smoke? Y/ N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?_____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____

_____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Is there anything that you feel is important that has not been covered?

_____

_____

_____