Adult Intake-Naturopathic

Name: _____ Date:_____

Date of birth: _____ Sex: M F

Address: _____
_____
_____
_____

Email address: _____

Would you like to receive our email newsletter? Y N
(We will not share your email address with anyone else)

Phone number: Home: _____ Cell/Work: _____

Can we leave messages relating to your visits (eg: reminder calls)? Y N

Emergency contact: Name: _____

Relation: _____ Phone number: _____

How did you hear about the clinic? _____
_____

Other health care providers you are seeing (ie. medical doctor, chiropractor, etc):

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(____)_____	(____)_____	(____)_____

Your health concerns in order of importance:

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

Medical History

List past or present serious conditions, illnesses, injuries and hospitalizations with approximate dates:

_____
_____
_____
_____
_____
_____
_____

Do you have any allergies (medications, environmental, etc)?

_____
_____
_____

List all current medications with dosage if known (including prescription and over the counter drugs, vitamins, supplements, herbs, homeopathics, etc):

_____
_____
_____
_____
_____
_____

Do you frequently use any of the following (please check yes or no):

	Yes	No	If yes, how often
Aspirin	____	____	_____
Tylenol	____	____	_____
Other painkillers	____	____	_____
Antacids	____	____	_____
Laxatives	____	____	_____
Diet pills	____	____	_____
Birth control pills	____	____	_____
Alcohol	____	____	_____

	Yes	No	If yes, form and how often
Tobacco	____	____	_____
Caffeine	____	____	_____
Recreational drugs	____	____	_____

Please list past prescription medications and indicate time of usage:
_____
_____
Do you get regular screening tests done by another doctor? (blood tests, Pap, etc) Y N

How long has it been since you last saw a medical doctor? _____
How many times have you been treated with antibiotics? _____
Have you recently gotten any vaccinations? Y N
If Yes, which ones:_____
Have you had any adverse reactions to vaccinations? _____
_____

Family Health History

Please indicate if a close relative (parent, grandparent, sibling, child, etc) has had any of the following:

	Family Member		Family Member
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Diabetes		Other	
Cancer			

Diet

Do you have any food allergies or sensitivities? Please list:
_____
_____
_____
_____

Do you have any food restrictions? (vegetarian, vegan, religious, etc)
_____
_____
_____
_____

Describe a typical day's diet:
Breakfast _____

Lunch _____
Dinner _____
Snacks _____
Beverages/water _____

Environment

Occupation _____
Hobbies _____

Do you exercise? Y N if yes, how often and what do you do? _____
_____
_____

Do you smoke? Y N

Are you exposed to second hand smoke (home, work, etc)? Y N

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

Are you regularly exposed to toxins or hazards (work, home, hobbies, etc)? Y N
Please describe: _____
_____
_____

How many hours do you sleep each night? _____
Do you sleep well, if no, please describe? _____
_____
_____

How stressful is your work or other areas of your life? How well do you handle stress? _____
_____
_____
_____
_____
_____

Describe the emotional climate of your home: _____
_____
_____
_____
_____

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

Check the conditions that you are currently experiencing, or have experienced often in the past.

	current	past
General Symptoms		
Loss of consciousness	□	□
Numbness / tingling	□	□
Fever/chills	□	□
Sweats	□	□
Fainting	□	□
Seizures/convulsions	□	□
Dizziness	□	□
Loss of sleep/insomnia	□	□
Frequent colds / flues	□	□
Loss of weight	□	□
Loss of memory	□	□
Fatigue/weakness	□	□
Depression	□	□
Anxiety	□	□
Head / Neck		
Headaches	□	□
Head injury	□	□
Vision problems	□	□
TMJ concerns	□	□
Earaches	□	□
Decreased hearing	□	□
Sinus problems	□	□
Difficulty swallowing	□	□
Frequent colds	□	□
Hayfever	□	□
Hoarseness	□	□
Skin		
Rashes / Eczema	□	□
Itching	□	□
Acne	□	□
Bruise easily	□	□
Dryness	□	□
Boils / Hives	□	□
Change in mole	□	□
Night sweats	□	□
Respiratory		
Chronic cough	□	□
Shortness of breath	□	□
Sputum	□	□
Wheezing	□	□
Breathing problems	□	□
Asthma / Bronchitis	□	□
Allergies	□	□

	current	past
Cardiovascular		
High blood pressure	□	□
Low blood pressure	□	□
Bleeding disorders	□	□
Anemia	□	□
Chest pain	□	□
Murmors	□	□
Palpitations/fluttering	□	□
Stroke	□	□
Artery hardening	□	□
Varicose veins	□	□
Swelling of the ankles	□	□
Poor circulation	□	□
Angina	□	□
Heart disease	□	□
Genitorurinary		
Pain on urination	□	□
Blood in the urine	□	□
Kidney stones	□	□
Urgency	□	□
Increased frequency	□	□
Hesitancy	□	□
Frequent infections	□	□
Prostate trouble	□	□
Gastrointestional		
Trouble swallowing	□	□
Poor digestion	□	□
Indigestion	□	□
Excessive hunger	□	□
Change in thirst	□	□
Change in appetite	□	□
Belching or gas	□	□
Nausea / Vomiting	□	□
Abdominal pain	□	□
Constipation	□	□
Diarrhea	□	□
Blood in stool	□	□
Black, tarry stool	□	□
Hemorrhoids	□	□
Liver concerns	□	□
Gall bladder trouble	□	□
Ulcer	□	□
Hernias	□	□
Diabetes	□	□

	current	past
Infections / Illnesses		
Herpes	□	□
Venereal disease	□	□
Hepatitis	□	□
Plantar warts	□	□
Tuberculosis	□	□
HIV / AIDs	□	□
Cancer	□	□
Muscles and Joints		
Stiff neck	□	□
Backache	□	□
Swollen joints	□	□
Foot trouble L / R	□	□
Shoulder pain L / R	□	□
Elbow pain L / R	□	□
Wrist pain L / R	□	□
Hip pain L / R	□	□
Knee pain L / R	□	□
Arthritis	□	□
Weakness / loss strength	□	□
Muscle spasms/cramps	□	□
Men's Health		
Testicular masses	□	□
Testicular pain	□	□
Sexual difficulties	□	□
Discharge or sores	□	□
Women's Health		
Painful menstruation	□	□
Painful intercourse	□	□
Excessive flow	□	□
Irregular cycle	□	□
Hot flushes	□	□
Cramps or backache	□	□
Vaginal discharge	□	□
Swollen/tender breasts	□	□
Lumps in the breast	□	□

Do you do self breast exams □ Yes □ No

Are you pregnant □ Yes □ No

On birth control □ Yes □ No

# of pregnancies _____

# of children _____

Date of last PAP _____