Adult Intake-Naturopathic

Name: ____ Date:______________

Date of birth: ________________ Gender: M F

Address: ____
____
____
____

Email address: ____

Would you like to receive our email newsletter? Yes No
(We will not share your email address with anyone else)

Phone number: Home: _____________________ Cell: ___________________
Work: _______________________

Would you like to receive confirmation emails when you schedule/change appointments?
Yes No

Our office will send appointment reminders 48 hrs prior to your appointment, **you must opt for at least 1:**

- ☐ Phone call- preferred phone to contact: ________________
- ☐ Email
- ☐ Text message

Optional additional reminders (we can send you as many as you like):

- ☐ Email 24 hours before
- ☐ Email 3 hours before
- ☐ Text message 24 hours before
- ☐ Text message 3 hours before
- ☐ Phone call 24 hours before

Insurance Provider

Primary: ______________________ Secondary: ___________________________

- ☐ I prefer to bill my own insurance
- ☐ I prefer the clinic to bill my insurance on my behalf

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 ____

Lifestyle/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 state 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.

General Symptoms

	current	past
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

	current	past
Headaches	☐	☐
Head injury	☐	☐
Vision problems	☐	☐
TMJ concerns	☐	☐
Earaches	☐	☐
Decreased hearing	☐	☐
Sinus problems	☐	☐
Difficulty swallowing	☐	☐
Frequent colds	☐	☐
Hayfever	☐	☐
Hoarseness	☐	☐

Skin

	current	past
Rashes / Eczema	☐	☐
Itching	☐	☐
Acne	☐	☐
Bruise easily	☐	☐
Dryness	☐	☐
Boils / Hives	☐	☐
Change in mole	☐	☐
Night sweats	☐	☐

Respiratory

	current	past
Chronic cough	☐	☐
Shortness of breath	☐	☐
Sputum	☐	☐
Wheezing	☐	☐
Breathing problems	☐	☐
Asthma / Bronchitis	☐	☐
Allergies	☐	☐

Cardiovascular

	current	past
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

	current	past
Pain on urination	☐	☐
Blood in the urine	☐	☐
Kidney stones	☐	☐
Urgency	☐	☐
Increased frequency	☐	☐
Hesitancy	☐	☐
Frequent infections	☐	☐
Prostate trouble	☐	☐

Gastrointestional

	current	past
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	☐	☐

Infections / Illnesses

	current	past
Herpes	☐	☐
Venereal disease	☐	☐
Hepatitis	☐	☐
Plantar warts	☐	☐
Tuberculosis	☐	☐
HIV / AIDs	☐	☐
Cancer	☐	☐

Muscles and Joints

	current	past
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

	current	past
Testicular masses	☐	☐
Testicular pain	☐	☐
Sexual difficulties	☐	☐
Discharge or sores	☐	☐

Women's Health

	current	past
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 _____________