



NATUROPATHIC ADULT INTAKE FORM

PERSONAL INFORMATION

Name _____ Date _____

Address _____

City _____ Province _____ Postal Code _____

Telephone # (home) _____

(work) _____

(cell) _____

May we leave a message for you? Y / N If so, at which number: _____

E-mail _____

Age _____ Date of Birth **(M/D/Y)** _____ Gender **F / M**

Married __ Partnership __ Separated __ Divorced __ Widowed __ Single __

Live with: Spouse __ Partner __ Parents __ Children __ Friends __ Alone __

Occupation _____ Hours per week _____ Retired _____

Person to contact in the event of an emergency

Relationship _____ Phone number

How did you hear about our clinic?

HEALTH OVERVIEW

Name of current general practitioner (MD) _____

GP's contact information _____ Last visit to your GP? _____

What was the reason?

When was your last physical exam?

Are you seeing a medical specialist? **Y / N** Name of specialist

If yes, for what reason?

When was your last visit to your dentist? _____ # of amalgam fillings _____



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PRESENT HEALTH CONCERNS: Please list in order of importance to you:

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

Can you trace the origin of any present health concerns to a particular circumstance, accident, illness, mental upset or unusual stress in your life? If yes, please explain.

What other therapies are you currently using? (Check ✓)

- Chiropractic
- Physiotherapy
- Massage Therapy
- Osteopathy
- Craniosacral Therapy
- Acupuncture
- Bowen Therapy
- Other

HEALTH HISTORY

How would you describe your state of health? (Check ✓) Excellent ___ Good ___ Fair ___ Poor ___

HOSPITALIZATIONS, SURGERIES, IMAGING

Please list any hospitalizations, surgeries, X-rays, and other imaging scans that you have had

_____ year: _____
_____ year: _____
_____ year: _____
_____ year: _____

CHILDHOOD ILLNESSES

Please circle all that apply and approximate age of illness (if known)

Chicken Pox	(age: _____)	Measles	(age: _____)
German Measles	(age: _____)	Chronic Ear Infections	(age: _____)
Respiratory Infections	(age: _____)	Scarlet Fever	(age: _____)
Diphtheria	(age: _____)	Rheumatic Fever	(age: _____)
Mumps	(age: _____)	Other (please list) _____	

IMMUNIZATIONS

Immunizations (Check ✓)

- | | | | |
|-----------------------------------|---|---------------------------------------|--------------------------------------|
| <input type="checkbox"/> DPT | <input type="checkbox"/> Hemophilus influenza B | <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Hepatitis B |
| <input type="checkbox"/> Flu shot | <input type="checkbox"/> Tetanus Booster | <input type="checkbox"/> MMR | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Smallpox | <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Other: _____ | |



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Any adverse reactions to vaccinations? **Y / N**

If yes, explain.

ALLERGIES / SENSITIVITIES

Please list all allergies, hypersensitivities, or intolerances (food, environmental, medications):

MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?	Reason
1.			
2.			
3.			
4.			
5.			

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Reason
1.			
2.			
3.			
4.			
5.			

Were you ever on antibiotics over the last 10 years? **Y / N**

Were you ever on antibiotics for an extended period of time? **Y / N**

If yes, please explain when and for how long

Have you ever used probiotics following antibiotic use? **Y / N**

FAMILY HISTORY

Please indicate whether any of your family members have, or have had the following:

Illness/Disease	Relative	Illness/Disease	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's Disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	



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LIFESTYLE

Please list any dietary restrictions (Vegan, vegetarian, religious, etc.)

What type of water do you drink? (circle): Tap Spring Distilled Reverse osmosis
How much? _____

Do you drink coffee? **Y/N** Cups/day: _____ Black tea? **Y/N** Cups/day: _____

Do you drink pop/soda? **Y/N** Cans/day: _____

Do you use artificial sweeteners (i.e. Splenda, Sucralose, etc.)? **Y/N** How often? _____

How many and what type of alcoholic beverages do you have per week?

Do you smoke? **Y/N**

How many cigarettes per
day? _____

Have you ever smoked? **Y/N** How many cigarettes per day?

Have you ever used recreational drugs? **Y/N**

If so, what drugs and how long did you use them?

STRESS

What level of personal stress are you experiencing right now? (Check ✓)

- Minimal
- Average
- Considerable
- Unbearable

Please circle your main stressors:

Financial	Job-related	Relationship
Health	Interpersonal	Unfulfilled expectations
Family members	Other _____	

What do you do for fun? (Hobbies, favourite activities, etc.)

How would you describe the emotional climate of your home?

Do you make time for rest, relaxation or meditation during the day and/or before bed? How do you relax?



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EXERCISE

Do you exercise regularly? **Y / N**

Type of Exercise	Frequency/week	Type of Exercise	Frequency/week

Do you enjoy exercise? **Y / N**

If you have difficulties committing to exercise, please state them:

SLEEP

Time you retire _____

Time you wake up _____

Do you have problems falling asleep? **Y / N**

Staying asleep? **Y / N**

Do you wake rested in the morning? **Y / N**

Do you have vivid/memorable dreams? **Y / N**

WOMEN'S HEALTH

Are you currently pregnant? **Y / N**

Do you intend to conceive? **Y / N**

If so, how soon? _____

Do you get regular Pap smears? **Y / N**

Date of last Pap? (month/year) _____ / _____

Have you ever had an abnormal Pap? **Y / N**

If yes, please explain:

Age of first period? _____

Is your period regular? **Y / N**

Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____

Do you experience PMS? **Y / N**

If yes, please state your symptoms:

Are you menopausal? **Y / N** If yes, age at last period _____

Are you currently sexually active? **Y / N**

Have you been sexually active in the past? **Y / N**

Current forms of contraception?

Have you ever had a sexually transmitted disease? **Y / N**



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Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you had any of the following concerning your breasts? (Please circle)

Pain Lumps Infections Cysts Nipple discharge

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

Do you have any sexual problems or concerns? **Y / N** If yes, explain.

MEN'S HEALTH

Do you get regular screening tests done (blood work, prostate examination)? **Y / N**

Date of last prostate examination? (month/year) _____ / _____

Are you currently sexually active? **Y / N**

Have you been sexually active in the past? **Y / N**

Current forms of contraception?

Do you have difficulty urinating completely? **Y / N**

How many times per night do you get up from your sleep to go to the bathroom?

Have you had any of the following? (circle)

Testicular pain Hernia STDs Discharge Sores

Do you have any sexual problems or concerns? **Y / N** If yes, explain.



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REVIEW OF SYSTEMS

Please circle if you are currently experiencing any of the following or write a P if you experienced it in the past.

General symptoms

Headache
Head injury
Fever
Chills
Sweats
Dizziness
Fainting
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in arms/legs
Allergy
Convulsions

Eyes, Ears, Mouth, Nose, Throat

Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sore throat
Hoarseness
Enlarged glands
Glaucoma
Failing vision
Cataracts
Eye pain
Ear discharge
Deafness
Ear ache
Nasal drainage

Cardiovascular

Low blood pressure
High blood pressure
Previous heart stroke
Hardening of the arteries
Swelling of the ankles
Poor circulation
Paralytic stroke
Irregular heart beat
Shortness of breath
Chest pain

Gastrointestinal

Excessive thirst
Excessive hunger
Belching
Gas (flatulence)

Skin

Hives or allergy
Acne or skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Change in mole

Nose bleeds
Nasal obstruction
Sinus infection
Hay fever
Mercury tooth fillings

Muscle & Joint

Stiff neck
Back pain
Muscle weakness
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders
Hernia
Spinal curvature
Faulty posture
Arthritis
Fracture/dislocation

Nausea
Vomiting
Vomiting of blood
Abdominal cramps
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver problems
Gallbladder problems
Jaundice
Colitis

Respiratory

Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Difficult breathing

Kidneys & Reproduction

Inability to control urine
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Kidney stones
Prostate trouble
Sores on genitals



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What are your treatment goals and expectations?

Is there anything else that you feel has not been covered that you would like me to know about?

***Thank you very much for taking the time to complete this form.
It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.***