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ADULT INTAKE FORM

Successful healthcare and preventive medicine require a healthy relationship between provider and patient. The nature of your responses to the following questions will significantly contribute to your doctor's understanding of you and your health history on many important levels. Your time, thoughtfulness, and honesty will help both of us to begin an appropriate course of treatment that is tailored to your needs and goals. Thank you!

PERSONAL INFORMATION:

Name ______________________________ Date of Birth _____________________ Age ____________

Address ____

City _____________________________________ State ___________ Zip Code _________________

Phone # home __________________ mobile __________________ Phone # (wk) __________________

Okay to leave a message re: appointments? __________Email ______________________________________

Occupation _______________________ Hours per week ________ Employer ________________________

Emergency contact ______________________ Relation? ___________ Phone: _______________________

How did you hear about our clinic? ____

Has any other **family member** been a patient at the clinic? ________________ Who? ______________________

What is your **main reason** for seeking naturopathic care? If you have a specific health condition for which you are seeking treatment, please describe it in detail. (Eg. When was the first time you noticed your condition and describe any factors that you suspect may have played a role in its onset and continuation.)
____
____
____
____

Please list **any other** health concerns (physical, emotional or mental) in order of importance:
____
____
____
____

Name of current **general practitioner** (MD):_______________________ Phone _______________________

List other **health professionals** you are seeing and include their area of practice (e.g. Massage).

____(Ph)_________________________

____(Ph)_________________________

____(Ph)_________________________

How do you rate your overall health? POOR FAIR AVERAGE GOOD EXCELLENT
How do you rate your overall energy? POOR FAIR AVERAGE GOOD EXCELLENT

Current Weight _____ Height _____ Wt. 1 yr ago _____ Max. adult Wt. _____ Min. adult weight ______

MEDICATIONS:
Please list all current medications (prescription and over-the counter):

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

Approximately how many times have you taken antibiotics? ____

Have you had an adverse reaction to a medication? NO/YES List the Medication: ___________________________

ALLERGIES:

List all (to medications, pollens, foods, animals etc.):

____

NATUROPATHIC REMEDIES:
List all naturopathic remedies (herbal, vitamin/mineral, nutritional, homeopathic etc.) you are taking:

1.	5.
2.	6.
3.	7.
4.	8.

CHILDHOOD MEDICAL HISTORY:

Please **CIRCLE** if you have had any of the following childhood **illnesses**:

Asthma
Chicken pox
Scarlet fever
Eczema
Frequent ear infections/colds
Measles
Mumps
Mono (how long? ________)
Polio
Rubella (German measles)
Rheumatic fever
Diptheria
Tuberculosis
Whooping cough
Other: ______________________

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IMMUNIZATIONS: (**CIRCLE** all the vaccinations that you have had)

DPT HAEMOPHILUS INFLUENZA B HEPATITIS A HEPATITIS B
MMR TETANUS CHICKEN POX SMALLPOX
POLIO FLU SHOT OTHER: ____

Any adverse reactions to a vaccination? Briefly describe if applicable:

____
____
____

Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations.

____
____
____

FAMILY HISTORY:

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

Condition	Relative	Condition	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart condition	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	
Bleeding disorders		Infertility	
Glaucoma		Thyroid Conditions	

LIFESTYLE FACTORS

Any current dietary restrictions? (vegan, vegetarian, etc.)

____

How much water do you drink in a day? _______________

On average, how many hours of sleep do you get each night? ____________ Good Quality? Y / N

Do you exercise? Y / N What type(s) of exercise and what frequency? ______________________________

____

What do you enjoy for recreation and relaxation?____

Do you have a religious or spiritual practice you would like us to know about? _____________________

____

Do you currently consume any of the following? (*Indicate how often, how much and for how long*)

Alcohol ________________________________ Tobacco ____
Coffee _________________________________ Soft drinks ______________________________________
Black tea ______________________________ Marijuana _______________________________________
Laxatives ______________________________ Other ____

Are you frequently exposed to animals? Y / N Exposed to toxins or hazards? Y / N, List: ___________________

Please list the five most significant, stressful events in your life, from the most recent to the most distant. Are any of these situations continuing to impact your life? (If so place a star next to the event)

1)____ Date________________
2)____ Date________________
3)____ Date________________
4)____ Date________________
5)____ Date________________

Relationship status: _____________________ Number of children+ ages: ______________________________

What is the emotional climate of your home?

____
____
____

Rate your current stress level (**CIRCLE**): LOW AVERAGE HIGH UNBEARABLE

Which factors most contribute to your stress? (**CIRCLE**)
HEALTH WORK MONEY FAMILY RELATIONSHIP OTHER:________________________

MALE REPRODUCTION

Do you have regular annual health screening tests? (blood work, prostate examination) Y / N

Date of last prostate examination? (month/yr) ____ / ____

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

Current forms of contraception?____

Any difficulty with urination? Y / N How often do you urinate at night? __________

Have you had any of the following? (**CIRCLE**)
TESTICULAR PAIN HERNIA STIs DISCHARGE SKIN LESIONS

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

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FEMALE REPRODUCTION

Are you currently pregnant? Y / N Estimated due date? ___________________________________

Do you get regular PAP smears Y / N Date of last PAP? (month/year) _____ / _____

Have you ever had an abnormal PAP? N / Y What was the outcome? ________________________________

Age of first period? ______ Is your period regular Y / N

Length of monthly cycle (eg 28,32)? ______ Average # days of period or flow? (3,5,7) _________

Do you experience PMS? Y / N Do you have spotting/bleeding between periods? Y / N

Please circle relevant PMS symptoms:

BLOATING	BREAST TENDERNESS	IRRITABILITY	DEPRESSION
HEADACHES	MOOD SWINGS	FOOD CRAVINGS	OTHER: _________________

Are you menopausal? Y / N If yes, age of last period _______________________

Are you 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 infection? Y / N

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

Have you ever had any of the following concerning your **breasts**? (**CIRCLE**)

PAIN LUMPSINFECTIONS 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? N/Y please explain: _______________________________

What expectations do you have of me as your physician?

____

____

____

What expectations do you have from this first visit to our clinic?

____

____

REVIEW OF SYSTEMS

Please **CIRCLE** if you are **currently** experiencing any of the following symptoms, OR if you have experienced any of these symptoms before write a "**P**" for **Past**.

GENERAL SYMPTOMS	EARS/EYES/NOSE/THROAT	CARDIOVASCULAR
Headache	Dental decay	Low Blood Pressure
Head injury	Gum disorder	High Blood Pressure
Fever	Enlarged thyroid	Previous Stroke
Chills	Tonsillitis	Hardening Arteries
Sweats	Sore Throat	Swelling of Ankles
Dizziness	Hoarseness	Poor Circulation
Fainting	Enlarged Glands	Paralytic Stroke
Loss of Sleep	Glaucoma	Irregular Heart Beat
Fatigue	Failing vision	Shortness of Breath
Nervousness/Anxiety	Cataracts	Chest Pain
Loss of Weight	Eye Pain	
Numbness/pain (extremeties)	Ear discharge	**GASTROINTESTINAL**
Allergies	Deafness	Bloating
Convulsions	Hay Fever	Excessive thirst
Depression	Mercury dental fillings	Excessive hunger
	Ear ache	Reflux
SKIN	Nasal Discharge	Eating Disorder
Change in mole(s)	Nose bleeds	Belching
Hives / allergic reactions	Nasal obstruction	Gas (flatulence)
Acne / skin eruptions	Sinus Infection	Nausea
Itching (ears, skin, rectum)		Vomiting
Bruising easily	**MUSCLE & JOINT**	Vomiting of blood
Dryness	Fracture/dislocation	Abdominal Cramps
Boils	Stiff neck	Constipation
Varicose veins	Back pain	Diarrhea
Sensitive skin	Muscle weakness	Hemorrhoids
	Swollen joints	Liver problems
KIDNEYS/REPRODUCTIVE	Painful tailbone	Jaundice
Prostate inflammation	Foot problems	Gallbladder issues
Genital lesions	Pain in shoulders	Irritable Bowel syndrome
Inability to control urine	Hernia	Crohn's Disease
Frequent urination	Spinal curvature	Ulcerative Colitis
Painful urination	Poor posture	
Blood in urine	Arthritis	**RESPIRATORY**
Pus in urine		Asthma
Kidney infection		Difficulty breathing
Kidney stones		Chronic cough
Erectile dysfunction		Spitting up phlegm
Infertility		Spitting up blood

Thank you for taking the time to fill this out completely!

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