

Intake Form

Personal Information

Date: _____

Name: _____ Sex: M F Age: _____ Birth Date: _____

Address: _____

City: _____ Province: _____ Postal code: _____

Telephone (Home): _____ (Work): _____ (Cell): _____

Email: _____

Preferred contact for appointment reminders: email phone

Occupation: _____ Employer: _____

Marital status: Married Single Widowed Divorced Separated Common-law

Number of children: _____

Other health care providers you are seeing:

	1	2	3
Name			
Occupation or Specialty			
Address			
Phone			
Fax			

In case of emergency, contact: _____ Relationship: _____ Phone: _____

How did you hear about the clinic? _____ Who can we thank? _____

Have you seen a Naturopathic Doctor before: Yes No If yes, for what ailment(s)? _____

Current History:

What health concerns brought you in to the clinic today?

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

Has anything changed recently or become worse?

Medication and Supplement History

Please list all supplements, herbs, and medications you are currently taking:

Medication/Supplement	Dosage	Since	Reason

When was the last time you used antibiotics? _____ Reason: _____

How many times (approx) have you used antibiotics in your life? _____

Do you frequently use any of the following? (check all that apply)

Aspirin Laxatives Antacids Diet pills Birth control: pills implants injections

Alcohol. Which type(s): _____ How many drinks/day or week: _____

Caffeine. Form: _____ Amount/day: _____

Tobacco. Form: _____ Amount/day: _____

Recreational drugs. What type? _____ How often: _____

Do you have a past history using any of the above? _____

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

Please list any past medications/supplements:

Medication/Supplement	Time taken	Reason

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: _____ Any adverse reactions? _____

Health History

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

Please list any serious conditions, illnesses, injuries, fractures, hospitalizations (any health history!):

Condition/illness/injury or hospitalization	Date	Complications or long term consequences?

Family History

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

Illness	Relative	Illness	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Mental illness		Suicide	
Liver disease		Other familial disease	

Gastrointestinal Health

How often do you have a bowel movement? _____

Do you tend towards: Constipation Diarrhea Both Neither

Have you had blood in your stool? Yes No Mucus? Yes No Black, tarry stool? Yes No

Do you have gas? Yes No Bloating? Yes No Heartburn? Yes No

Diet

Do you have any food allergies or intolerances? _____

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

How much water do you drink per day? _____

Please jot down a typical day's diet:

Breakfast	Lunch	Dinner	Drinks/Snacks

Lifestyle/Environment

Do you sleep well? Yes No On average, how many hours of sleep do you get a night? _____

Do you exercise regularly? Yes No What do you do for exercise? How often? _____

Are you exposed to significant tobacco smoke (work, home, etc)? Yes No

Are you frequently exposed to animals (work, pets, etc)? Yes No

Are you regularly exposed to toxins or other hazards? Yes No Which ones? _____

Please rate your stress level: Low Average High unbearable

How would you describe the emotional climate of your home?

How do you deal with your stress? _____

Women's Health

Are you currently pregnant? Yes No

Do you get Pap smears? Yes No Last Pap date: _____ Have you had an abnormal Pap: Yes No

Age of first period: _____ Is your period regular? Yes No Length of cycle (Days): _____ Flow (Days) _____

Are you menopausal? Yes No If yes, age of last period: _____

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No

Current form of contraception: _____

Have you ever had a sexually transmitted infection? Yes No

Number of pregnancies? _____ Live births? _____ Miscarriages? _____ Abortions? _____

Do you have any sexual problems of concern? Yes no. If yes, please explain: _____

Men's Health

Do you get regular screening tests done (blood work, prostate examinations)? Yes No

Date of last prostate exam? _____

Are you currently sexually active? Yes No Have you been sexually active in the past? Yes No

Current form of contraception: _____

Have you had any of the following: Testicular pain Hernia STI's Discharge Sores

Do you have any sexual problems of concern? Yes no. If yes, please explain: _____

Review of Systems

Please check off all that apply. C = currently experiencing. P = experienced in the past.

C	P	General	C	P	Cardiovascular	C	P	Muscle, Bone & Joints
<input type="checkbox"/>	<input type="checkbox"/>	Headaches	<input type="checkbox"/>	<input type="checkbox"/>	High/low blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Back pain
<input type="checkbox"/>	<input type="checkbox"/>	Poor/change in appetite	<input type="checkbox"/>	<input type="checkbox"/>	Irregular heartbeat	<input type="checkbox"/>	<input type="checkbox"/>	Muscle spasms/cramps
<input type="checkbox"/>	<input type="checkbox"/>	Weight change (___lbs)	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness / Fainting	<input type="checkbox"/>	<input type="checkbox"/>	Muscle weakness
<input type="checkbox"/>	<input type="checkbox"/>	Chills and fevers	<input type="checkbox"/>	<input type="checkbox"/>	Chest pain/Angina	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis/joint pain
<input type="checkbox"/>	<input type="checkbox"/>	Night sweats	<input type="checkbox"/>	<input type="checkbox"/>	Anemia			Female
<input type="checkbox"/>	<input type="checkbox"/>	Excessive sweating	<input type="checkbox"/>	<input type="checkbox"/>	Easy bruising/bleeding	<input type="checkbox"/>	<input type="checkbox"/>	Irregular or painful periods
<input type="checkbox"/>	<input type="checkbox"/>	Cravings	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Heavy/light flow
<input type="checkbox"/>	<input type="checkbox"/>	Intense hunger	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands or feet	<input type="checkbox"/>	<input type="checkbox"/>	Blood clots
<input type="checkbox"/>	<input type="checkbox"/>	Intense thirst	<input type="checkbox"/>	<input type="checkbox"/>	Swelling of limbs	<input type="checkbox"/>	<input type="checkbox"/>	Pain during intercourse
		Skin & Hair	<input type="checkbox"/>	<input type="checkbox"/>	Date of last CBC: __/__/____	<input type="checkbox"/>	<input type="checkbox"/>	Vaginal discharge/itching
<input type="checkbox"/>	<input type="checkbox"/>	Rashes/Itching/Hives			Respiratory	<input type="checkbox"/>	<input type="checkbox"/>	Yeast infections
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Difficulty breathing	<input type="checkbox"/>	<input type="checkbox"/>	Sore breasts
<input type="checkbox"/>	<input type="checkbox"/>	Acne, Boils	<input type="checkbox"/>	<input type="checkbox"/>	Chronic cough	<input type="checkbox"/>	<input type="checkbox"/>	Do self breast exams?
<input type="checkbox"/>	<input type="checkbox"/>	Loss of hair/dandruff			Sputum			Male
<input type="checkbox"/>	<input type="checkbox"/>	Nail Changes	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia/Bronchitis	<input type="checkbox"/>	<input type="checkbox"/>	Testicular masses
<input type="checkbox"/>	<input type="checkbox"/>	Mole colour change	<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Testicular pain
		Eyes, Ears, Nose & Throat	<input type="checkbox"/>	<input type="checkbox"/>	Coughing blood	<input type="checkbox"/>	<input type="checkbox"/>	Prostate problems
<input type="checkbox"/>	<input type="checkbox"/>	Impaired hearing	<input type="checkbox"/>	<input type="checkbox"/>	Shortness of breath	<input type="checkbox"/>	<input type="checkbox"/>	Impotence
<input type="checkbox"/>	<input type="checkbox"/>	Ear aches / infections	<input type="checkbox"/>	<input type="checkbox"/>	Wheezing	<input type="checkbox"/>	<input type="checkbox"/>	Do testicular self exams?
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears			Gastrointestinal	<input type="checkbox"/>	<input type="checkbox"/>	Neurological
<input type="checkbox"/>	<input type="checkbox"/>	Sinus infections	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	Depression
<input type="checkbox"/>	<input type="checkbox"/>	Enlarged thyroid	<input type="checkbox"/>	<input type="checkbox"/>	Hiatal Hernia	<input type="checkbox"/>	<input type="checkbox"/>	Irritability
<input type="checkbox"/>	<input type="checkbox"/>	Recurrent sore throats	<input type="checkbox"/>	<input type="checkbox"/>	Bad breath	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory
<input type="checkbox"/>	<input type="checkbox"/>	Nosebleeds	<input type="checkbox"/>	<input type="checkbox"/>	Nausea	<input type="checkbox"/>	<input type="checkbox"/>	Dizziness
<input type="checkbox"/>	<input type="checkbox"/>	Eye strain / blurry vision	<input type="checkbox"/>	<input type="checkbox"/>	Abdominal pain/cramps	<input type="checkbox"/>	<input type="checkbox"/>	Seizures
<input type="checkbox"/>	<input type="checkbox"/>	Night / colour blindness	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	Concussion
<input type="checkbox"/>	<input type="checkbox"/>	Glasses/contacts			Genito-Urinary	<input type="checkbox"/>	<input type="checkbox"/>	Numbness in fingers/toes
<input type="checkbox"/>	<input type="checkbox"/>	Change in Prescription	<input type="checkbox"/>	<input type="checkbox"/>	Frequent /urgent urination	<input type="checkbox"/>	<input type="checkbox"/>	Mood swings
<input type="checkbox"/>	<input type="checkbox"/>	Cataracts	<input type="checkbox"/>	<input type="checkbox"/>	Pain on urination			
<input type="checkbox"/>	<input type="checkbox"/>	Itchy/red eyes	<input type="checkbox"/>	<input type="checkbox"/>	Urinary tract infections			
<input type="checkbox"/>	<input type="checkbox"/>	Facial pain/tics	<input type="checkbox"/>	<input type="checkbox"/>	Wake at night to urinate			
<input type="checkbox"/>	<input type="checkbox"/>	Jaw pain or clicks	<input type="checkbox"/>	<input type="checkbox"/>	Incontinence			
<input type="checkbox"/>	<input type="checkbox"/>	Mercury fillings	<input type="checkbox"/>	<input type="checkbox"/>	Kidney stones			
<input type="checkbox"/>	<input type="checkbox"/>	Sores in mouth	<input type="checkbox"/>	<input type="checkbox"/>	Blood in urine			
<input type="checkbox"/>	<input type="checkbox"/>	Loss of taste						

Was there anything missed on this form that you would like to address?

I thank you - and your health thanks you - for taking the time filling out this form! It will bring insight to your intake and treatment plan.