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ADULT INTAKE FORM

Please complete this form and return it on your first visit

Name: _____ Date: _____

Address: _____

Telephone numbers: (h) _____ (w) _____
May we leave messages for you at these numbers? ___YES ___NO

E-mail: _____

Referred by: _____

Family Medical Doctor _____

Other Primary Care Givers _____

Emergency Contact _____

THE FOLLOWING INFORMATION IS CONFIDENTIAL AND WILL NOT BE
RELEASED WITHOUT YOUR WRITTEN PERMISSION

PERSONAL HEALTH PROFILE

A note to patients: Naturopathic, holistic and preventative health care is only possible when the doctor has a complete picture of the patient physically, mentally and emotionally. Therefore, please take the time to carefully and thoroughly complete this health history questionnaire. Consider making a copy for your own records.

Age: _____ Date Of Birth: _____ Sex: _____
 Marital Status: _____ Name of spouse/partner: _____
 Number of children (if applicable): _____
 Occupation: _____ No. of work hours/week: _____
 Are you fulfilled in your current position? If not, please explain:

Last physician or health care practitioner seen? _____ When? _____

When was your last physical exam? _____ Blood tests done? Yes/No Blood Type _____

What is your primary health concern: _____

How long have you had this condition? _____

Do you have a medical diagnosis for this condition? _____

If yes, name of physician who made the diagnosis: _____

When was this diagnosis made: _____

How have you been treated to date: _____

Additional Health Concerns and Goals

List health concerns in order of importance to you. Please list any health goals that you would like to achieve. When possible, indicate the month and year that the health condition started and present treatments.

	Health Concern/Goal	Month/Year	Treatments/Comments
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

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Past Health History

Please list and describe any surgeries and/or hospitalization.

Surgery/Hospitalization	Date	Comments

Immunizations: check all that apply.

- MMR
- Polio
- Small Pox
- Hib
- Typhoid
- DPT
- Meningitis
- Flu
- Hepatitis
- Other:

Have you had any reactions to vaccinations? Yes/No If yes, please describe:

Childhood illness: check all that apply

- Measles
- Rubeola
- Rheumatic Fever
- Other: _____
- Mumps
- Whooping cough
- Chicken Pox
- Rubella
- Asthma
- Scarlet Fever

Health Conditions: check all that apply.

Condition	Now	Past	Never	Condition	Now	Past	Never
Anemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypoglycemia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Arthritis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Allergies	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Asthma	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Emphysema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Alcoholism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Migraines	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Bleeding	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Pneumonia	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Cancer	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Bronchitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Colitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Tuberculosis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Heart disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Rheumatism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
High blood pressure	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hypothyroidism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Injury	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hyperthyroidism	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Kidney disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Eczema	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Liver disease	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Psoriasis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Obesity	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Canker Sores	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Ulcers	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Fainting	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Diabetes	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Balance Problems	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Depression	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Jaundice	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Epilepsy	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Hepatitis	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Gas/Bloating	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	Cold hands/feet	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Are there any of these from which you feel you have never been well since? _____

Family History

Please list ages and if deceased, what they died from and at what age.

Mother _____ Father _____
Grandmother _____ Grandmother _____
Grandfather _____ Grandfather _____
Siblings _____

Have any of your family members (including aunts, uncles, etc.) had any of the following conditions?

- Alcoholism
- Allergies
- Anemia
- Arthritis
- Asthma
- Cancer
- Depression
- Diabetes
- Drug Addiction
- Epilepsy
- Headaches
- Heart Disease
- Hypertension
- Kidney Disease
- Mental Illness
- Stroke
- Tuberculosis
- Other?

Lifestyle Factors

Do you use tobacco products? ___Yes ___No How often? _____

Are you exposed to tobacco products in your home or workplace? ___Yes ___No

Do you consume alcohol? ___Yes ___No How often? _____

Do you use recreational drugs? ___Yes ___No How often? _____

Do you exercise regularly? ___Yes ___No How often? _____

What types of activities do you do to relax? _____

You currently live with? Spouse ___Partner ___Parents ___Friends ___Children ___Alone ___

How would you describe the emotional climate of your home? _____

Personal Habits

What do you enjoy most in life? _____
What do you worry about most in life? _____
What nurtures you? _____
Do you have a religions/spiritual practice? Yes/No
On a scale of 1-10, how would you rate the quality of your sleep? _____
How many hours of sleep do you get? _____ Do you wake refreshed? _____
How is your body temperature compared to other? Warmer Cooler Average
How often do you get colds, flus, sore throats in a year? _____

Reproductive

Are you sexually active? Yes/No Is this more or less than one year ago? _____
Sexual Preference: Heterosexual _____ Bisexual _____ Homosexual _____
Do you use birth control? Yes/No What type? _____

Female

Age of first menses _____ If periods have stopped, at what age did they stop? _____
Are your cycles regular? Yes/No Periods begin every _____ days, and last _____ days
Are your periods **heavy, medium, light**? What is the color of the blood? _____
Are there any clots? Yes/No Any cramps with your period? Yes/No
Do you have spotting/bleeding between periods? Yes/No Every month? _____

Do you have any premenstrual symptoms? **Water retention irritability depression headaches anger breast tenderness mood swings crying bloating acne cravings other?** _____

Number of pregnancies _____ Number of abortions _____ Number of miscarriages _____
Number of live births _____ Any problems getting pregnant? _____
Do you get regular pap smears? Yes/No Any abnormal pap's? Yes/No
Do you do regular breast self exams? Yes/No

Male

How often do you get up in the night to urinate? _____ Has this increased lately? _____
Do you have trouble achieving/maintaining an erection? Yes/No
Do you have any sores or discharge from your penis? Yes/No
Have you had your prostate examined? Yes/No When? _____

Kidney and Bladder

Have you had a bladder infection? Yes/No How often? _____ Treatment? _____
Do you have a burning sensation during or after urination? Yes/No
Is your urine **dark yellow bright yellow cloudy pale/clear strong odour**
Do you have any difficulty starting/stopping when urinating?

Perspiration

Do you have any difficulty perspiring? Yes/No Any strong odour? Yes/No
Do you perspire when exercising? **Lightly** **Moderately** **Heavily**

Digestion and Elimination

Do you have any problems with gas, bloating or fullness after meals? Yes/No

How often is this a problem? **Often** **Sometimes** **Never**

How long have you had this problem? _____

How often do you have bowel movements? _____

Do you ever have any **blood** **mucous** **undigested food** **black stools**

Any rectal itching? Yes/No

Are your stools **formed or loose** Any diarrhea? _____

Ever have alternating constipation and diarrhea Yes/No How often? _____

Do you ever have yellow or light coloured stools? Yes/No

Do you ever have to strain to pass stools? Yes/ No How often? _____

Do you pass gas frequently? Yes/No Do you burp frequently? Yes/No

Do your stools ever have a strong, disagreeable odour? Yes/No

Please use the space below to add any additional information that has not been covered in this questionnaire.