Dr. Jennifer Salib Huber, B.Sc (Hons), P.Dt., N.D
10 Portland Street – Suite 101
Dartmouth, NS B2Y 1G9
Tel: (902)444-3303 Fax: (902)444-3853
www.pillarsofhealth.ca

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:_____
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			

Have you ever seen a: Naturopathic Doctor Chiropractor Acupuncturist
Massage Therapist Osteopath Other_____

How would you describe the general state of your health?
Excellent__ Good__ Average__ Fair__ Poor__

How long has it been since you have experienced excellent health?_____
_____

Please list the 5 most significant, stressful events in your life:

1)_____Date_____
2)_____Date_____
3)_____Date_____
4)_____Date_____
5)_____Date_____

Are any of these situations continuing to impact your life? Yes/no (please circle number)

Please list any prescription medication you are **currently** taking.

Prescription	Prescribed for	Dosage

In the past 5 years, how often have you been prescribed antibiotics?_____

Do you take any of the following on a regular basis? Circle all that apply.

Aspirin Tylenol Laxative Antacids Muscle relaxants Sleeping pills

Do you have any **allergies** to medications? ___Yes ___No
If so, please list:_____

Please list any vitamins/herbs that you are **currently** taking**.**

Supplement	Taking for	Dosage

Past Health History

Please list and describe any surgeries and/or hospitalization.

Surgery/Hospitalization	Date	Comments

Childhood illness: check all that apply

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

Health Conditions: check all that apply.

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

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/NoIs this more or less than one year ago?____
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?

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 you 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.