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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 \_\_\_\_\_  
\_\_\_\_\_

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

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## 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

- |                                  |   |  |                                       |
|----------------------------------|---|--|---------------------------------------|
| <input type="checkbox"/> Measles | <input type="checkbox"/> Rubeola        | <input type="checkbox"/> Rheumatic     | <input type="checkbox"/> Other: _____ |
| <input type="checkbox"/> Mumps   | <input type="checkbox"/> Whooping cough | <input type="checkbox"/> Fever         |                                       |
| <input type="checkbox"/> Rubella | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Chicken Pox   |                                       |
|                                  |   | <input type="checkbox"/> Scarlet Fever |                                       |

**Health Conditions:** check all that apply.

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

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

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## 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?

- |                                  |                                      |                                      |
|----------------------------------|--------------------------------------|--------------------------------------|
| <input type="radio"/> Alcoholism | <input type="radio"/> Depression     | <input type="radio"/> Hypertension   |
| <input type="radio"/> Allergies  | <input type="radio"/> Diabetes       | <input type="radio"/> Kidney Disease |
| <input type="radio"/> Anemia     | <input type="radio"/> Drug Addiction | <input type="radio"/> Mental Illness |
| <input type="radio"/> Arthritis  | <input type="radio"/> Epilepsy       | <input type="radio"/> Stroke         |
| <input type="radio"/> Asthma     | <input type="radio"/> Headaches      | <input type="radio"/> Tuberculosis   |
| <input type="radio"/> Cancer     | <input type="radio"/> Heart Disease  | <input type="radio"/> 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? \_\_\_\_\_

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You currently live with? Spouse \_\_\_Partner \_\_\_Parents \_\_\_Friends \_\_\_Children \_\_\_Alone \_\_\_

How would you describe the emotional climate of your home? \_\_\_\_\_

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## 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? \_\_\_\_\_  
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 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.