Naturopathic Adult Intake Form

Date:____________________

First Name:____________________ Last Name:________________________________

Date of Birth: (MM/DD/YYYY)_____________Age: _____Sex: Male ☐ Female ☐

Street Address:____

City:____________________ Province:_______________ Postal Code:___________

Telephone: Home: ______________________________

Work: ______________________________

Cell: ______________________________

Email Address:____

How do you prefer to be contacted? ____

Emergency Contact Name:____

Emergency Contact Number:____

How did you hear about the clinic?____

Occupation and Employer:____

Marital Status:____________________________ Number of Children:___________

Current Health Care Providers:

1. ____Phone:__________________
2. ____Phone:__________________
3. ____Phone:__________________

What is your MAIN concern for your visit today?

____

____

____

List other health problems you are experiencing:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________

MEDICATIONS/ SUPPLEMENTS

Please list CURRENT medications and/or supplements:______________________

____

____

____

____

____

Please list PAST medications and/or supplements: :______________________

____

____

____

____

HEALTH HISTORY

Please list all known allergies (include foods, environmental and medications): ______________________

____

____

____

Please list previous surgeries/hospitalizations/injuries (include dates if possible):______________________

____

____

____

VACCINATION HISTORY

Please indicate which of the following vaccinations you have received

☐ DPT (Diphtheria, Pertussis, Tetanus)

☐ Tetanus booster

☐ MMR (Measles, Mumps and Rubella)

☐ Hepatitis A

☐ Hepatitis B

☐ HiB (Haemophilus Influenza B)

☐ Polio

☐ Flu Shot

☐ H1N1 Swine Flue Shot

☐ Other____

Have you ever had an adverse reaction to a vaccination, if yes please explain?

____

____

LIFESTYLE

Do you exercise? Yes ☐ No ☐ If yes, how often? ___________________________

How is your body temperature on average? Warm ☐ Cool ☐ Average ☐

How much water do you drink each day?_________________________________

How would you rate your overall WELL-BEING from 1-10 (10 is the best)?

0 ←---→10

How would you rate your ENERGY level each day from 1-10 (10 is the best)?

0 ←---→10

How would you rate your SLEEP from 1-10 (10 is the best)?

0 ←---→10

In which position do you sleep? Back ☐ On Side ☐ Stomach ☐ Other:_________

How many hours of sleep do you get each night?________________________________

Do you awake refreshed? Yes ☐ No ☐ Do you sweat at night? Yes ☐ No ☐

Please indicate if you use any of the following: Alcohol ☐ Artificial Sweeteners ☐ Coffee ☐ Other Caffeinated Beverages ☐ Recreational Drugs ☐ Soda Pop ☐ Tobacco ☐ Sedatives ☐ Laxatives ☐ Antacids ☐ Pain Relief Medications ☐

PAST MEDICAL HISTORY

Please indicate which of the following you have **NOW (N)** or in the **PAST (P)**

Alcoholism		Gallstones		Ringing in Ears	
Allergies		Gas/Bloating		Scarlet fever	
Anemia		Gout		STI	
Arthritis		Hay fever		Sinusitis	
Asthma		Headaches		Sleep Problems	
Back Pain		Heart Disease		Speech Problems	
Balance Problems		Hemorrhoids		Strep Throat	
Bladder Infections		Hepatitis		Stroke	
Broken Bone		Hypertension		Thyroid Problems	
Cancer		Jaundice		Tonsillitis	
Canker Sores		Measles		Tuberculosis	
Chicken pox		Mental Illness		Varicose Veins	
Cold Hands/Feet		Migraines		Vision Problems	
Constipation		Miscarriage		Warts	
Depression		Mononucleosis		Weight Problems	

Diabetes		Mumps		Whooping Cough	
Diarrhea		Muscle Tension		Yeast Infections	
Ear Infection		Numbness/Tingling		Child Abuse	
Eczema		Parasites		Physical Abuse	
Epilepsy		Pneumonia		Sexual Abuse	
Fainting		Poor memory		Emotional Abuse	
Frequent Urination		Psoriasis		Rape	

FAMILY HISTORY

	Main Health Concerns (or if applicable, cause of death)
Mother	
Father	
Brother(s)	
Sister(s)	
Children	
Maternal Grandmother	
Maternal Grandfather	
Paternal Grandmother	
Paternal Grandfather	

~Thank-you for filling out this lengthy questionnaire, it is a valuable tool in understanding your health history~