

Naturopathic Medicine INTAKE FORM

PERSONAL INFORMATION

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex/gender: _____

Home Address: _____

City: _____ Postal Code: _____

Home Telephone: _____ Other Telephone: _____

What number may we leave messages at? _____

Email address: _____

(would you like to be included in our e-mail list? Yes No)

How did you find out about us? (please check all that apply)

- | | |
|---------------------------------------|--|
| <input type="checkbox"/> Yellow Pages | <input type="checkbox"/> Friend Whom should we thank? _____ |
| <input type="checkbox"/> Webpage | <input type="checkbox"/> Professional referral Whom should we thank? _____ |
| <input type="checkbox"/> OAND | <input type="checkbox"/> Other |

Health Care Team:

Family Physician: _____ Phone: _____

Other Health Care Providers: _____ Phone: _____

Date of last physical exam: _____ Blood tests done? Y N

Do you get regular screening tests done by a doctor? (Pap, blood, etc.) Y N

CHIEF HEALTH CONCERNS: What are your health concerns in order of importance

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list approximate dates and reasons:

ENVIRONMENT AND LIFESTYLE

Occupation: _____

Do you exercise regularly? Y N

What types: _____ How often? _____

What is your social support network? _____

Do you: Live alone Live with partner Live with friends Other

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

What causes you the most stress in life? _____

How do you manage your stress? _____

Do you currently face or have you faced any of the following?

	√ = yes	Year		√ = yes	Year
Loss of someone close			Divorce		
Illness in someone close			Pregnancy		
Loss of job			Alcohol/drug addiction		
Change of job			Alcohol/drug addiction in someone else		
Change of workplace			Physical abuse		
A move			Emotional abuse		
Marriage			Sexual abuse		
Separation			Other (please specify)		

HEALTH HISTORY:

Do you have any allergies (foods, environmental, medications)? Please List

Allergy	What problems do they give you? Diarrhea, stuffy nose, anaphylaxis, etc.	How often are you exposed? Daily, weekly, monthly, etc.	When did you first become aware of the allergy/problem?

Please list all current **prescription medications**:

Name of medication	Dose	Frequency	Duration	Side effects (if any)

Please list all **vitamins, herbs, homeopathics, and non-prescription medications** that you take on a regular basis:

Name and Brand	Dose	Frequency	Duration	Side effects (if any)

Approximately how many times per year have you been treated with antibiotics?

As a child? _____ As an Adult? _____

How often do you use the following:

	Per day	Per week	Per Month
Caffeine			
Cigarettes			
Diet pills			
Pain Relievers			
Antacids			
Laxatives			
Alcohol			
Recreational Drugs			
Fast Food			

Do you follow any special dietary plans? (Religious, vegetarian, vegan, etc.)

List any foods that you crave or make you feel better:

Food/drink the you crave	Approximately how often do you have them? (daily, weekly, etc.)

GENERAL HISTORY:

(For the following list of symptoms: √ for currently experiencing and P for those you've had in the past)

<p>SKIN:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rashes <input type="checkbox"/> Eczema <input type="checkbox"/> Psoriasis <input type="checkbox"/> Vitilago <input type="checkbox"/> Dryness <input type="checkbox"/> Hives <input type="checkbox"/> Boils <input type="checkbox"/> Acne <input type="checkbox"/> Warts <p>HEAD:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Head injury <input type="checkbox"/> Headaches/migraines <input type="checkbox"/> Vertigo/Dizziness <input type="checkbox"/> Hair loss <input type="checkbox"/> Dandruff <p>EYES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Redness <input type="checkbox"/> Excessive tearing <input type="checkbox"/> Double/Blurred vision <input type="checkbox"/> Spots/floaters <input type="checkbox"/> Flashing lights <input type="checkbox"/> Glaucoma <input type="checkbox"/> Cataracts <input type="checkbox"/> Discharge/infection <p>EARS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Infection <input type="checkbox"/> Ringing <input type="checkbox"/> Hearing loss <p>NOSE & SINUSES:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Frequent colds <input type="checkbox"/> Nasal stuffiness <input type="checkbox"/> Loss of smell <input type="checkbox"/> Nose bleeds <input type="checkbox"/> Nasal Polyps <input type="checkbox"/> Sinus Infections <input type="checkbox"/> Chronic runny nose 	<p>MOUTH & THROAT:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Bleeding gums <input type="checkbox"/> Sores in mouth <input type="checkbox"/> Periodontal disease <input type="checkbox"/> Thrush <input type="checkbox"/> Sore throat <input type="checkbox"/> Enlarged lymph nodes <input type="checkbox"/> Torticollis/stiff neck <p>RESPIRATORY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Cough <input type="checkbox"/> Wheezing <input type="checkbox"/> Asthma <input type="checkbox"/> Bronchitis <input type="checkbox"/> Pneumonia <input type="checkbox"/> Emphysema <input type="checkbox"/> Coughing blood <input type="checkbox"/> Tuberculosis <input type="checkbox"/> Central chest pain <p>CARDIOVASCULAR:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Rapid heart beat <input type="checkbox"/> High blood pressure <input type="checkbox"/> Chest pain <input type="checkbox"/> Palpitations <input type="checkbox"/> Heart murmurs <input type="checkbox"/> Rheumatic fever <input type="checkbox"/> Difficult breathing <input type="checkbox"/> Leg cramps <input type="checkbox"/> Thrombophlebitis <input type="checkbox"/> Edema/swollen ankle <input type="checkbox"/> Cold hands/feet <p>INTESTINAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Trouble swallowing <input type="checkbox"/> Nausea <input type="checkbox"/> Vomiting <input type="checkbox"/> Heartburn/regurgitation <input type="checkbox"/> Indigestion <input type="checkbox"/> Bloating <input type="checkbox"/> Abdominal pain <input type="checkbox"/> Excessive gas <input type="checkbox"/> Ulcer 	<ul style="list-style-type: none"> <input type="checkbox"/> Hypoglycemia <input type="checkbox"/> Diabetes <input type="checkbox"/> Jaundice/hepatitis <input type="checkbox"/> Colitis or Chron's <input type="checkbox"/> Constipation <input type="checkbox"/> Blood in stool <input type="checkbox"/> Diarrhea <input type="checkbox"/> Hemorrhoids <input type="checkbox"/> Eating disorder <p>GENITOURINARY:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Urgency <input type="checkbox"/> Dribbling/leaking <input type="checkbox"/> Frequency <input type="checkbox"/> Incontinence <input type="checkbox"/> Burning pain <input type="checkbox"/> Urinary tract infxns <input type="checkbox"/> Kidney infxns <input type="checkbox"/> Kidney stones <input type="checkbox"/> STDs (HPV, etc.) <p>GENERALS:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Weight loss/gain <input type="checkbox"/> Fatigue <input type="checkbox"/> Night sweats <input type="checkbox"/> Profuse perspiration <input type="checkbox"/> Weakness <input type="checkbox"/> Insomnia <p>FEMALE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> PMS <input type="checkbox"/> Menopause <input type="checkbox"/> Low libido <input type="checkbox"/> Yeast infections <input type="checkbox"/> Vaginal Dryness <input type="checkbox"/> Painful periods <input type="checkbox"/> Irregular Periods <input type="checkbox"/> Excessive discharge <input type="checkbox"/> Miscarriage(s) <input type="checkbox"/> Pregnancy(s) <input type="checkbox"/> Abortion(s) <input type="checkbox"/> Endometriosis 	<ul style="list-style-type: none"> <input type="checkbox"/> Uterine fibroids <input type="checkbox"/> Cervical Dysplasia <input type="checkbox"/> Fibrocystic Breasts <p>MALE:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Enlarged prostate <input type="checkbox"/> Prostatitis/infxn <input type="checkbox"/> Discharge <input type="checkbox"/> Low libido <input type="checkbox"/> Erectile dysfunction <p>HAEMATOLOGICAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Anemia <input type="checkbox"/> Easy bleeding <input type="checkbox"/> Easy Bruising <input type="checkbox"/> Varicose/spider veins <input type="checkbox"/> Past transfusions <input type="checkbox"/> Hep. A, B, or C <input type="checkbox"/> HIV <p>MUSULOSKELETAL</p> <ul style="list-style-type: none"> <input type="checkbox"/> Muscle pains <input type="checkbox"/> Joint pains <input type="checkbox"/> Osteo-arthritis <input type="checkbox"/> Back pain <input type="checkbox"/> Muscle spasms/cramps <input type="checkbox"/> Joint swelling <input type="checkbox"/> Gout <p>NEUROLOGICAL:</p> <ul style="list-style-type: none"> <input type="checkbox"/> Fainting/Black outs <input type="checkbox"/> Numbness <input type="checkbox"/> Tremors <input type="checkbox"/> Pins & needles <input type="checkbox"/> Loss of balance <input type="checkbox"/> Paralysis <input type="checkbox"/> Speech problems <input type="checkbox"/> Memory loss <input type="checkbox"/> Loss of sleep <input type="checkbox"/> Nervousness/tension <input type="checkbox"/> Irritability <input type="checkbox"/> Depression
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FAMILY HEALTH HISTORY:

Please indicate if a close relative (parent, grandparent, or sibling) has had any of the following)

	Mother	Father	Sibling	Grandparent	Aunt/uncle
Allergies					
Arthritis					
Asthma					
Autoimmune Disease					
Cancer					
Diabetes					
Heart Disease					
High Blood Pressure					
Mental Illness					
Multiple Sclerosis					
Stroke					
Tuberculosis					
Macular degeneration					
Glaucoma					
Thyroid conditions					
other					