

## Adult Naturopathic Intake Form

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Phone numbers: (H) \_\_\_\_\_ (W) \_\_\_\_\_

Email: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth (MM/DD/YY): \_\_\_\_\_ Sex: \_\_\_\_\_

Who referred you to us? \_\_\_\_\_

Would you like to receive email newsletters from our clinic? \_\_\_\_\_

Would you like to receive appointment reminders through e-mail? \_\_\_\_\_

\*\*Naturopathic and preventative health care are greatly facilitated when the doctor has a complete picture of the client physically, mentally, and emotionally. Therefore, please take the time to thoroughly complete this health history questionnaire.

**Primary Health Concerns:** Please list in order of importance to you

- |          |          |
|----------|----------|
| 1. _____ | 5. _____ |
| 2. _____ | 6. _____ |
| 3. _____ | 7. _____ |
| 4. _____ | 8. _____ |

### CONTEXT OF CARE OVERVIEW

1. Why did you choose to come to this clinic?

What do you know about our approach?

2. What three expectations do you have from this visit to our clinic?

What long term expectations do you have from working with our clinic?

What expectations do you have of me personally as your physician?

3. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

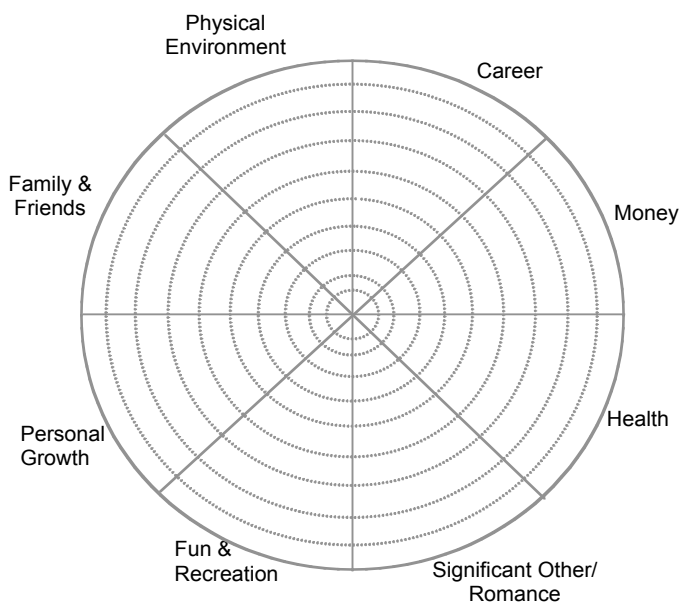
4. a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

5. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

6. Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

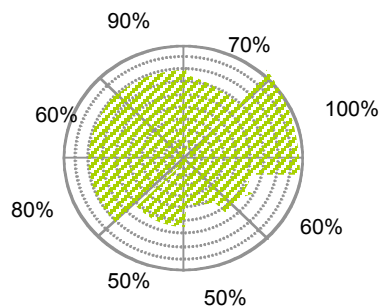
7. What do you LOVE to do?



100  
%

80%

Example:



## Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have caused or contributed to your health problems?

---

Please list all former treatments that you have used both conventional and alternative and the degree of effectiveness of each treatment.

---



---



---

If female are you currently pregnant?  yes  no

**Medical History**

What childhood illnesses have you had?

- |  |   |                                  |
|--|---|----------------------------------|
| <input type="checkbox"/> Rubella (german measles- 3 day) | <input type="checkbox"/> Measles (2 week) | <input type="checkbox"/> Mumps   |
| <input type="checkbox"/> Chicken pox                     | <input type="checkbox"/> Whooping cough   | <input type="checkbox"/> Polio   |
| <input type="checkbox"/> Rheumatic fever                 | <input type="checkbox"/> Scarlet fever    | <input type="checkbox"/> Roseola |
| <input type="checkbox"/> Asthma                          | <input type="checkbox"/> Other            |                                  |

	Now	Past	Never		Now	Past	Never
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<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"/>	Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver dz/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Other	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				
Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>				

Please indicate any serious conditions, illnesses or injuries and any hospitalizations; along with approximate dates.

---



---



---

**Medications/Supplements:** Please list all of your present medications including drugs, supplements, homeopathics and herbs along with dosages.

---



---



---

Please list all past prescription medications.

---



---

How many times have you been treated with antibiotics? \_\_\_\_\_

Do you have any allergies (drug, other substances, environmental)?

---

---

---

What symptoms do you experience with an allergy attack?

---

---

Check off any of the following types of allergy testing that you have had:

Intradermal  Scratch  Blood IgG food   
Food intolerance testing  Kinesiology  Blood IgE inhalant/food

Do you frequently use any of the following?

Aspirin  Laxatives   
Diet pills  Antacids   
Alcohol  How much per day or week? \_\_\_\_\_  
Tobacco  Form and amt per day \_\_\_\_\_  
Caffeine  Form and amt per day \_\_\_\_\_  
Recreational drugs  Form and frequency \_\_\_\_\_

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

Yes  No

**Family History:** Please list ages and if deceased, what they died from and at what age.

**Mother's side**

Mother \_\_\_\_\_  
Grandfather \_\_\_\_\_  
Grandmother \_\_\_\_\_  
Your sisters \_\_\_\_\_

**Father's side**

Father \_\_\_\_\_  
Grandfather \_\_\_\_\_  
Grandmother \_\_\_\_\_  
Your brothers \_\_\_\_\_

**Please indicate if a close relative has had any of the following:**

Condition	Who?	Condition	Who?
Allergies		Hay fever	
Anemia		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Bleeding		Seizure/epilepsy	
Cancer		Sickle cell anemia	
Diabetes		Stroke	
Depression		Thyroid (hyper/hypo	
Drug/alcohol abuse		Tuberculosis	
Eczema		Venereal disease (std)	
Glaucoma		Other	
Gout			

**Social History:**

Occupation: \_\_\_\_\_

Do you enjoy your work? Or is it a job that you feel you must do in order to make a living?

---

---

How would you describe your relationship with your co-workers?

---

---

Does income meet monthly expenses? \_\_\_\_\_

Are you currently  married  divorced Number of children \_\_\_\_\_

How would you describe your family relationships?

---

---

Have you traveled outside of Canada in the past year? \_\_\_\_\_

Do you exercise regularly?  yes  no What do you do for exercise, how much, how often?

---

---

What are your hobbies? \_\_\_\_\_

---

---

How often do you drink wine \_\_\_\_\_ beer \_\_\_\_\_ other alcohol \_\_\_\_\_

Do you use tobacco or have you in the past?  yes  no Years since quitting \_\_\_\_\_

Are you exposed to significant tobacco smoke (work, home etc.)? \_\_\_\_\_

---

---

Do you now or have you in the past used marijuana or other drugs?  yes  no

If yes, which drugs, how often and how long? \_\_\_\_\_

Have you ever been exposed to toxic chemicals, solvents or other possible toxins?

---

---

Do you make time for rest, relaxation or meditation during the day and/or before bed? How do you relax?

---

---

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

---

---

How stressful is your work or other aspects of your life? How well do you handle these stresses?

---

---

**Sleep:**

Do you have trouble falling asleep?  yes  no

Do you have trouble staying asleep?  yes  no

**Home environment:**

Are your home and work environments well-ventilated?  yes  no

Are your home and work environments excessively  moist  dry

**Diet:**

Do you have any food intolerances or allergies? Please list.

---

---

Do you have any dietary restrictions (religious, vegetarian, vegan etc.)?

---

---

How many meals do you generally eat each day? \_\_\_\_\_

Where do you usually buy your food? \_\_\_\_\_

**Describe a typical day's diet:**

Breakfast \_\_\_\_\_

Snack \_\_\_\_\_

Lunch \_\_\_\_\_

Snack \_\_\_\_\_

Dinner \_\_\_\_\_

Snack \_\_\_\_\_

Beverages (and total quantity) \_\_\_\_\_

Do you regularly consume any of the following (include approximate amount)?

Coffee  \_\_\_\_\_

Caffeinated teas  \_\_\_\_\_

Processed foods  \_\_\_\_\_

Refined foods  \_\_\_\_\_

Other food that you suspect may be harmful to your health \_\_\_\_\_

List any foods that you crave regardless of their nutritional value (includes chocolate, sweets, sour, salty, bread, rich/fatty food):

Are you thirsty?  yes  no Amount of water you drink each day \_\_\_\_\_

Are you satisfied with your diet the way it is now? Why or why not? \_\_\_\_\_

**Female:**

Do you perform regular breast self examinations? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_

Type of contraception used? \_\_\_\_\_

Have you ever used birth control pills? \_\_\_\_\_

Did you experience any side effects? \_\_\_\_\_

Age of first menstruation \_\_\_\_\_ Did you have a normal puberty? \_\_\_\_\_

Is your cycle regular?  yes  no Periods occur every \_\_\_ days and usually last \_\_\_ days

Date of last period: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Was it normal?  yes  no

Have you ever had any problems with infertility? \_\_\_\_\_

# of pregnancies: \_\_\_ # of births: \_\_\_ # of miscarriages: \_\_\_ # of abortions: \_\_\_

Have you ever had any pregnancy complications? \_\_\_\_\_

Please write a short description of how you see yourself: