NATUROPATHIC ADULT INTAKE FORM

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GENERAL

Name:	Date of 1st Visit :	
Date of Birth :	Age:	Gender: M F
Address:		
City:	Prov:	Postal Code:
Phone (home):	Phone (work):	
Phone (cell):	Email:	
Occupation:	Hours worked per week:	
Marital Status: ❑ Single ❑ Common-law ❑ Same-Sex ❑ Married ❑ Separated ❑Divorced ❑ Widowed		
Live with (check all that apply): ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone		
Number of Children:	Ages & Gender of children:	

EMERGENCY CONTACT

Name:	Relationship:
Phone (home):	(work/cell):

OTHER HEALTH CARE PROVIDERS

1.	2.
Phone:	Phone:
Fax:	Fax:
3.	4.
Phone:	Phone:
Fax:	Fax:

Do you have regular screening tests done by another doctor? (Pap, annual physical, blood work, etc) ❑ yes ❑ no

Date of last physical exam: _____

How did you hear about our clinic? _____

HEALTH CONCERNS

Reason for visit (list in order of importance):

_____

_____

_____

_____

_____

How long have you had this condition?

_____

_____

_____

_____

_____

What type of therapies have you tried in the past for these concern(s)?

❑ Diet Modification ❑ Vitamins/minerals ❑ Detoxification ❑ Herbs ❑ Homeopathy ❑ Chiropractic
❑ Acupuncture ❑ Pharmaceuticals ❑ Other _____

What was the outcome? _____

FAMILY HISTORY

Please check any the following that a family member has experienced:

❑ Arthritis
❑ Asthma
❑ Alzheimer's Disease
❑ Autoimmune (MS, Lupus, etc)
❑ Cancer
❑ Depression
❑ Diabetes
❑ Eczema
❑ Drug Addiction/Alcoholism
❑ Heart disease
❑ High Blood Pressure
❑ Migraine headaches
❑ Psoriasis
❑ Kidney Disease
❑ Stroke
❑ Thyroid Issues
❑ Mental Illness
❑ Other _____

HEALTH HISTORY

How would you rate your general current state of health on the following scale:
1 2 3 4 5 6 7 8 9 10

Current prescription(s) and/or over the counter medication(s):

_____

_____

Current supplements and/or vitamins:

_____

_____

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year Illness, Surgery, Injury, Major Medical Diagnosis

_____ _____

_____ _____

_____ _____

Do you have any allergies (foods, medications, environmental, etc.)

_____

_____

Do you frequently use any of the following?

❑ Aspirin	❑ Antacids	❑ Birth control
❑ Laxatives	❑ Diet pills	❑ Tylenol/Advil/Ibuprofen
❑ Alcohol	Type and amount per day/week:	
❑ Tobacco	Form and amount/day:	
❑ Caffeine	Form and amount/day	
❑ Recreational drugs	What and how often:	

Please check all of the following that apply to you:

EXERCISE

- ❑ No formal exercise
- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ less than 30 minutes duration per workout
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight train
- ❑ Yoga
- ❑ Swim
- ❑ Other _____

NUTRITION & DIET

- ❑ Mixed food diet (animal and vegetable)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat Restriction
- ❑ Carbohydrate Restriction
- ❑ Religious restriction(s)
- ❑ Food intolerances
- ❑ Other _____

FOOD FREQUENCY

- ❑ Skip Breakfast
- ❑ One meal per day
- ❑ Two meals per day
- ❑ Three meals per day
- ❑ Graze (small frequent meals)
- ❑ Eat constantly whether hungry or not
- ❑ Eat on the run
- ❑ Add salt to food

SLEEP

- ❑ Wake feeling rested
- ❑ Wake feeling tired
- ❑ 8-10 hours per night
- ❑ 6-8 hours per night
- ❑ Less than 6 hours per night
- ❑ Undisturbed sleep
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Please rate your quality of sleep on the following scale (1 being the least):

1 2 3 4 5 6 7 8 9 10

Please rate your current stress level on the following scale (1 being the least):

1 2 3 4 5 6 7 8 9 10 Source: _____

Do you consider yourself: ❑ Overweight ❑ Underweight ❑ Just right Your weight _____

Have you experienced any unintentional weight loss of 10 lbs or more over the last 3 months? ❑ Yes ❑ No

Are you exposed to any harmful chemicals (e.g. smoke, renovations, pesticides)? ❑ Yes ❑ No
If so, please describe. _____

_____

Is there anything else you feel is important to add?

_____

_____