**Adult Intake Form**

*Dear Patient: Please complete this questionnaire with care. Your answers will help me to determine the most effective care for you. This is a confidential record of your medical history. It will not be released without your prior authorization.*

Full Name: Click here to enter text. Date: Click here to enter a date. Address: Click here to enter text.

Telephone: (Home) Click here to enter text. (Work) Click here to enter text. (Cell) Click here to enter text. Email: Click here to enter text. Fax: Click here to enter text. Age: Click here to enter text. Birth Date: Click here to enter a date. Occupation: Click here to enter text.

Would you like appointment reminders? [ ]  No [ ]  Email [ ]  Phone

Would you like to receive our quarterly email newsletter? Yes [ ]  No [ ]

How did you hear of this office: Choose an item. Other? Click here to enter text.

Referred by: Click here to enter text.

Have you received Naturopathic Care before? Choose an item. If yes, when? Click here to enter text.

Name of practitioner(s): Click here to enter text. For what reason? Click here to enter text.

Name of Medical Doctor (MD): Click here to enter text. Phone: Click here to enter text.

Emergency Contact (Name & Phone Number): Click here to enter text.

**Health History**

Major concerns in order of importance:

|  |  |
| --- | --- |
| **1.**Click here to enter text. | **5.**Click here to enter text. |
| **2.**Click here to enter text. | **6.**Click here to enter text. |
| **3.**Click here to enter text. | **7.**Click here to enter text. |
| **4.**Click here to enter text. | **8.**Click here to enter text. |

When did you last feel well? Click here to enter text.

Have you had X-rays in the last 5 years? Choose an item. Please list areas: Click here to enter text.

Weight: Click here to enter text. Height: Click here to enter text. Blood Type: Click here to enter text.

Are you satisfied with your present weight? Choose an item. Have you ever had a weight concern? Choose an item.

What vaccinations have you had? (Check which apply): [ ] **DPTP** [ ] **MMR** [ ]  **TETANUS** [ ] **SMALLPOX** [ ] **FLU VACCINE**

PRESCRIPTION medications you take on a regular basis, including birth control:

|  |  |  |  |
| --- | --- | --- | --- |
| **Name of Medication** | **Date Started** **(Month/Year)** | **Frequency** | **Dosage** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

NON-PRESCRIPTION medications taken on a regular basis, including vitamins/minerals/herbs:

|  |  |
| --- | --- |
| **Supplement/Vitamin** | **Dose** |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. |

Are you allergic to any medication? Choose an item.

If yes, which ones? Click here to enter text.

Do you have any dietary restrictions? Choose an item. If yes, please explain: Click here to enter text.

Are you currently following any special diets? Choose an item.

If yes, please explain: Click here to enter text.

List all surgeries, hospitalizations, accidents: Click here to enter text.

Your usual health is: Choose an item.

Number of times you exercise at least 30 minutes (check box): [ ] 0 [ ]  1-2 [ ]  3-4 [ ]  >5 /wk

**Family History** (Parents, siblings, grandparents, aunts, uncles)

|  |  |  |  |
| --- | --- | --- | --- |
| **Disease** | **Who?** | **Disease** | **Who?** |
| Anemia | Click here to enter text. | High Cholesterol | Click here to enter text. |
| Arthritis | Click here to enter text. | Diabetes | Click here to enter text. |
| Eczema | Click here to enter text. | Asthma | Click here to enter text. |
| Epilepsy | Click here to enter text. | Cancer | Click here to enter text. |
| Glaucoma | Click here to enter text. | Alcoholism | Click here to enter text. |
| Thyroid Disease | Click here to enter text. | Drug Addiction | Click here to enter text. |
| Heart Disease | Click here to enter text. | Psychiatric Illness | Click here to enter text. |
| High Blood Pressure | Click here to enter text. | Other: | Click here to enter text. |

Do you meditate or use any relaxation exercise? Click here to enter text.

What are the things you find most stressful? Click here to enter text.

What level of personal stress are you experiencing right now? Choose an item.

Main Stressor (Check all that apply): [ ]  **Financial** [ ] **Job Related** [ ]  **Interpersonal**

[ ] **Marriage** [ ] **Health** [ ] **Family Members** [ ] **Spiritual** [ ] **Unfulfilled Expectations** [ ] **Other**

STRESSES – Which, if any, of the following have you experienced?

[ ] Loss of someone close [ ] Divorce

[ ] Illness of someone close [ ] Pregnancy

[ ] Loss of job [ ] Alcohol/Drug Addiction

[ ] A move [ ] Physical Abuse

[ ] Marriage [ ] Emotional Abuse

[ ] Separation [ ] Other (please specify) Click here to enter text.

**Smoking History**

Do you currently smoke tobacco? Choose an item. If yes, how many per day? Click here to enter text.

How many years? Click here to enter text.

If you previously smoked when did you quit? Click here to enter text.

How many a day did you smoke?Click here to enter text.

How many years did you smoke? Click here to enter text.

Does anyone else smoke in your household? Choose an item. Does anyone smoke at your workplace? Choose an item.

**Sleep**

Do you have regular sleeping habits? Choose an item. How many hours? Click here to enter text.

Check any applicable: [x]  **Early riser** [ ]  **Difficulty falling asleep** [ ]  **Wake during the night** [ ]  **Nightmares**

How often do you have a full and complete bowel movement? Click here to enter text. **How many cups/bottles/glasses do you drink on the average day?**

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Beverage** | **Amount** | **Beverage** | **Amount** | **Beverage** | **Amount** |
| Water | Click here to enter text. | Fruit Juice | Click here to enter text. | Coffee | Click here to enter text. |
| Tea | Click here to enter text. | Veg Juice | Click here to enter text. | Beer | Click here to enter text. |
| Soft Drinks (regular) | Click here to enter text. | Herbal Tea | Click here to enter text. | Wine | Click here to enter text. |
| Soft Drinks (Diet) | Click here to enter text. | Milk | Click here to enter text. | Liquor | Click here to enter text. |

**Dental Health**

How often do you see your dentist? Click here to enter text.

How many mercury fillings do you have? Click here to enter text. How many have you replaced? Click here to enter text.

Do you have any other metal in your mouth? Click here to enter text.

Have you had any root canals? Click here to enter text.

Do you colour your hair? Choose an item. If your hair has turned grey, what age were you? Click here to enter text.

How old is your home? Click here to enter text.

Has there been any kind of renovations/construction in your home recently? (Dry wall, paint, new carpets)? Click here to enter text.

Do you use a microwave oven? Choose an item. Electric Blanket? Choose an item. Water bed? Choose an item.

**Travel Illnesses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Illness/Symptoms** | **Location Travelled** | **Age** | **Year** |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |
| Click here to enter text. | Click here to enter text. | Click here to enter text. | Click here to enter text. |

**For Women**

Status: Choose an item.Number of children: Click here to enter text. Age(s): Click here to enter text.

Number of pregnancies: Click here to enter text. Deliveries: Click here to enter text.

Miscarriages: Click here to enter text. Abortions: Click here to enter text.

Were there any complications associated with the above? Click here to enter text.

Age of first menses? Click here to enter text. Are your menses regular? Choose an item.

Age of cessation of menses Click here to enter text.

The blood flow during the menses is (Check applicable): [ ] **Not at all** [ ] **Spotting** [ ] **Heavy** [ ] **Moderate** [ ] **Heavy and Clots**

Pain with the menses: Choose an item.

**PMS QUESTIONNAIRE – Rate each of the following symptoms of your last menstrual cycle only.**

**0** if not experienced

**1** if mild (present but does not interfere with activities)

**2** if moderate (present and interferes with activities but not disabling)

**3** if severe (disabling; unable to function)

|  |  |  |  |
| --- | --- | --- | --- |
| **Symptoms** | **Rating** | **Symptoms** | **Rating** |
| Anxious | Choose an item. | Weight gain | Choose an item. |
| Irritability | Choose an item. | Swelling of extremities | Choose an item. |
| Mood Swings | Choose an item. | Breast tenderness | Choose an item. |
| Nervous Tension | Choose an item. | Abdominal bloating | Choose an item. |
| Headache | Choose an item. | Depression | Choose an item. |
| Craving for sweets | Choose an item. | Forgetfulness | Choose an item. |
| Increased appetite | Choose an item. | Crying | Choose an item. |
| Heart palpitations | Choose an item. | Confusion | Choose an item. |
| Fatigue | Choose an item. | Insomnia | Choose an item. |
| Dizziness or faintness | Choose an item. |  |  |

Are you now on or have you ever taken birth control pills? Choose an item.

If yes, how long? Click here to enter text.

Are you now or have you ever used any hormone-modulating medications in the form of pills, patches, or creams (estrogen, progesterone, or birth control pills)? If yes, please list the type, dosage and frequency. Click here to enter text.

Have you ever experienced fibrocystic disease of the breast? Choose an item.

Have you ever had uterine fibroids? Choose an item.

Do you have recurring vaginal infections? Choose an item.

Do you self-exam your breast for lumps regularly? Choose an item. Last pap smear? Click here to enter text.