**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.*

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone: (home) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (work/other) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_ Birth Date: (Day/Month/Year) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Would you like appointment reminders? (circle one) No Phone Email

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

How did you hear of this office (circle one): *Friend Relative Website Newspaper Ad*

*Health Care Professional Other* Referred by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you received Naturopathic Care before? *YES NO* If yes, when? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of practitioner(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ For what reason? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of Medical Doctor (MD): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency Contact (Name & Phone Number) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Health History**

Major concerns in order of importance:

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

When did you last feel well? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had X-rays in the last 5 years? *YES NO* Please list areas:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Weight: \_\_\_\_\_\_\_\_\_\_\_ Height: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ Blood Type: \_\_\_\_\_\_\_\_\_\_\_\_\_

Are you satisfied with your present weight? *YES NO* Have you ever had a weight concern? *YES NO*

What vaccinations have you had? (Circle 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** |
|  |
|  |
|  |
|  |
|  |

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

|  |  |
| --- | --- |
| **Supplement/Vitamin** | **Dose** |
|  |  |
|  |  |
|  |  |
|  |  |
|  |  |

Are you allergic to any medication?  *YES NO*

If yes, which ones? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any dietary restrictions? *YES NO*

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently following any special diets? *YES NO*

If yes, please explain: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

List all surgeries, hospitalizations, accidents: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Your usual health is: □ Excellent □ Good □ Fair □ Poor

Number of times you exercise at least 30 minutes: □ 0 □ 1-2 □ 3-4 □ over 5/week

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

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

Do you meditate or use any relaxation exercise? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What are the things you find most stressful? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What level of personal stress are you experiencing right now? (Circle which apply):

*MINIMAL AVERAGE CONSIDERABLE UNBEARABLE*

Main Stressor (Circle which apply to you):  *Financial Job Related Interpersonal*

*Marriage Health Family Members Spiritual Unfulfilled Expectations Other*

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

□ 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)

**Smoking History**

Do you currently smoke tobacco? *YES NO* If yes, how many per day? \_\_\_\_\_\_\_\_\_\_

How many years? \_\_\_\_\_\_\_\_\_\_ If you previously smoked when did you quit? \_\_\_\_\_\_\_\_\_\_\_

How many a day? \_\_\_\_\_\_\_\_\_\_ How many years? \_\_\_\_\_\_\_\_\_\_\_\_

Does anyone else smoke in your household? *YES NO*

 Does anyone smoke at your workplace? *YES NO*

**Sleep**

Do you have regular sleeping habits? *YES NO* How many hours? \_\_\_\_\_\_\_\_\_\_\_\_\_

Circle any applicable: *Early riser Difficulty falling asleep Wake during the night Nightmares*

How often do you have a full and complete bowel movement? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many cups/bottles/glasses do you drink on the average day?

|  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- |
| **Beverage** | **Amount** | **Beverage** | **Amount** | **Beverage** | **Amount** |
| Water |  | Fruit Juice |  | Coffee |  |
| Tea |  | Veg Juice |  | Beer |  |
| Soft Drinks (regular) |  | Herbal Tea |  | Wine |  |
| Soft Drinks (Diet) |  | Milk |  | Liquor |  |

**Dental Health**

How often do you see your dentist? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many mercury fillings do you have? \_\_\_\_\_\_\_\_\_\_ How many have you replaced? \_\_\_\_\_\_\_

Do you have any other metal in your mouth? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you had any root canals? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you colour your hair?  *YES NO* If your hair has turned grey, what age were you?\_\_\_\_\_\_\_

How old is your home? \_\_\_\_\_\_\_\_ Has there been any kind of renovations/construction in your home recently? (Dry wall, paint, new carpets)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you use a micro-wave oven? *YES NO* Electric Blanket? *YES NO* Water bed? *YES NO*

**Travel Illnesses**

|  |  |  |  |
| --- | --- | --- | --- |
| **Illness/Symptoms** | **Location Travelled** | **Age** | **Year** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**For Women**

Status: *Single Married Common-law Widowed Divorced*

Number of children: \_\_\_\_\_\_\_ Age(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of pregnancies: \_\_\_\_\_\_ Deliveries: \_\_\_\_\_\_\_ Miscarriages: \_\_\_\_\_\_\_ Abortions: \_\_\_\_\_\_

Were there any complications associated with the above? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Age of first menses \_\_\_\_\_ Are your menses regular? *YES NO* Age of cessation of menses \_\_\_

The blood flow during the menses is (Circle which apply): *Not at all Spotting Moderate Heavy Heavy and Clots*

Pain with the menses (Circle which apply):  *Not at all Slight Moderate Severe Incapacitating*

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** | **0, 1, 2, 3** | **Symptoms** | **0, 1, 2, 3** |
| Anxious |  | Weight gain |  |
| Irritability |  | Swelling of extremities |  |
| Mood Swings |  | Breast tenderness |  |
| Nervous Tension |  | Abdominal bloating |  |
| Headache |  | Depression |  |
| Craving for sweets |  | Forgetfulness |  |
| Increased appetite |  | Crying |  |
| Heart palpitations |  | Confusion |  |
| Fatigue |  | Insomnia |  |
| Dizziness or faintness |  |  |  |

Are you now on or have you ever taken birth control pills? *YES NO* if yes, how long? \_\_\_\_

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. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Have you ever experienced fibrocystic disease of the breast? *YES NO*

Have you ever had uterine fibroids? *YES NO*

Do you have recurring vaginal infections (Circle which apply)?  *Never Rarely Frequently More than 3 a year*

Do you self-exam your breast for lumps regularly? *YES NO*  Last pap smear?\_\_\_\_\_\_\_\_\_\_