Family Naturopathic Clinic

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ADULT INTAKE FORM:

Name: _____ Sex: M/F Age: _____
Street Address: _____
City: _____ Province: _____ Postal Code: _____
Phone: _____ Email: _____
Date of Birth: (MM/DD/YYYY) _____ Place of Birth: _____
Occupation: _____
Marital Status: _____ Name of Spouse: _____
Name of Family Doctor: _____
Who referred you to the clinic? _____

Present weight: _____
Normal weight: _____
When were you last this weight? _____
What is your chief concern about your health?

_____
_____
_____

If this is a chronic condition, how long have you had this condition? _____
Who diagnosed your illness? _____
When was the diagnosis made? _____
What specialists have you seen? (Please indicate year of consultation)

_____
_____

How has your condition(s) been treated until now?

_____

What else would you like to see changed in your health? (Indicate how long you have had each of these conditions.)

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

How long has it been since you have been totally well? _____

Previous History: Write a checkmark if you have experienced any of the following.

Measles		Gallstones		Bowel disease	
Mumps		High Blood Pressure		Rashes	
Scarlet Fever		Pleurisy		Malaria	
Whooping Cough		Arthritis		Gonorrhea	
Croup		Rheumatism		Chlamydia	
Pneumonia		Gout		Asthma	
Tuberculosis		Genital Herpes		Constipation	
Mononucleosis		Hay Fever		Diphtheria	
Ear Infections		Chicken Pox		Candida	
Depression		Allergies		Hypoglycemia	
Sinusitis		Colds and Flus		Swollen glands	
Eczema		Cancer		Parasites	
Diabetes		Kidney conditions		Stroke	
Hyperthyroidism		Angina		Shingles	
Hypothyroidism		TMJ Dysfunction		Urinary Tract Infection	
Alcoholism		Anemia		Back & Neck pain	
Chronic fatigue		Fibromyalgia		Dental disorders	
Meningitis		Ringing in ears/Tinnitus		Jaundice	
Digestive disorders		Environmental Illness		Crohn's disease	
Stomach ulcer		Hepatitis		Celiac disease	
Insomnia		Learning Disorders		Varicose veins	
Headaches		Obesity		Trauma	
Eye disorders		Hemorrhoids		Infertility	
Lyme's disease		Osteoporosis		Covid	

Other: _____

Were any of the above severe? If so give age, severity and duration.

_____

_____

_____

Do you donate blood on a regular basis? Yes _____ No _____
Have you donated blood in the past? Yes _____ No _____

Infectious Disease Status:

Did you receive a blood transfusion in Canada between 1980-1990? Yes _____ No _____
Do you have Hepatitis A, B, or C? Yes _____ If yes, which one(s)? _____ No _____
Are you HIV positive or do you have AIDS? Yes _____ No _____
Are you in close contact with an infected person who has one of the above diseases?
Yes _____ No _____
List any other infectious diseases that you have

_____

Describe your general state of health as a child

_____
_____
_____

Describe your general state of health as a teenager

_____
_____
_____

Surgeries: Please indicate the type of surgery, date and where it was performed.

_____
_____

Accidents: Please indicate the injuries sustained, severity, when they occurred, and any necessary treatments.

_____
_____

Family History: Please indicate the age of all your immediate family members living (L) and indicate the age at which any member became deceased (D).

Father	L _____	D _____	Mother	L _____	D _____
Brothers	L _____	D _____	Sisters	L _____	D _____
	L _____	D _____		L _____	D _____
	L _____	D _____		L _____	D _____

Indicate the *number* of relatives: grandparents, parents, brothers, or sisters who have or had the following diseases.

Diabetes		Cancer		Heart disease	
Mental Illness		Alzheimer's disease		Tuberculosis	
Arthritis		High blood pressure		Allergies	
Kidney disease		Stomach disorders			

Additional Male History:

Have you ever had any prostrate problems? Yes _____ No _____
If yes, please describe _____

Have you ever experienced any bladder problems? Yes _____ No _____

Please list any other male conditions you have:

_____
_____
_____
_____

Additional Female History:

Age of first period/menses _____ Age of cessation of menses _____
Are your menses regular? _____ Irregular? _____
Do you experience PMS symptoms? Yes _____ No _____
If yes, what do you experience?

_____
_____

Have you experienced fibrocystic disease of the breast? Yes _____ No _____
Have you ever had uterine fibroids? Yes _____ No _____
Do you have recurring vaginal infections? Never _____ Rarely _____ Frequently _____
More than three times a year _____
Number of children _____ Ages: _____
Number of pregnancies _____ Deliveries: _____
Miscarriages _____ Abortions _____
Were there any complications associated with the above?

_____
_____
_____

Please list any other female conditions that you have.

_____
_____

Medications:

List all the prescribed medications you are *currently* taking. Indicate the drug name, dosage, frequency, and how long you have been taking it.

1. _____
2. _____
3. _____
4. _____
5. _____

List all prescribed medications that you have taken in the past for any period of time longer than three months.

1. _____
2. _____
3. _____
4. _____
5. _____

List any prescribed medications that you have had a bad reaction to in the past. Indicate the drug name, when you took it, and the adverse reaction you had.

1. _____
2. _____
3. _____

How many courses of antibiotics have you had in the past ten years? _____
Have you had a bad reaction to any antibiotics? Yes _____ No _____

List any over-the-counter medications you take (i.e. Aspirin, Tylenol, Tums)
Indicate whether you take them rarely, occasionally, frequently, or daily.
1. _____
2. _____
3. _____

Have you ever used recreational drugs? Yes _____ No _____
Do you currently use recreational drugs? Yes _____ No _____
If yes, indicate type and frequency of usage.
_____
_____

Have you received a vaccine(s) for Covid 19? Yes _____ No _____
If yes, which vaccine and how many doses? _____
Have you ever had a severe reaction from a vaccination? Yes _____ No _____
If yes, explain vaccination type, when it was administered, and the reaction.
_____
_____
_____

List all food supplements you are presently taking. Indicate the total dosage taken daily (i.e. If you take 2 tablets of Vitamin C 500mg/day, the total is 1000 mg.)
1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____

Lifestyle:

How many cups/bottles/glasses do you drink of the following on an average day?
Coffee _____ Tea _____ Herbal Tea_____ Milk 2% _____
Milk (skim) _____ Fruit Juice _____ Soft drinks (regular)_____ Soft drinks (diet)____
Vegetable juice _____Beer _____ Wine_____ Water _____ Liquor _____
How often would you have an alcoholic beverage per week? _____

Do you smoke? Yes _____ (How many cigarette/day? _____ Cigars/day _____) No _____
Have you ever smoked? _____ For how long? _____
Does anyone else smoke in the household? Yes _____ No _____
Does anyone smoke in your workplace? Yes _____ No_____

List any work-related or household environmental concerns and hazards.

_____
_____
_____

How many hours do you work each week? _____

What do you do for exercise? (Indicate type of exercise, and frequency per week)

_____
_____
_____

What do you do for recreation? _____
What are your hobbies? _____

How many hours per day do you watch television and surf the internet? _____

What, if any, pets do you have? _____

How many hours of sleep do you get on average? _____

When was your last vacation? How long was it? _____

What level of personal stress (related as a percentage) are you currently experiencing in each of the following areas?

Financial _____	Job related _____	Interpersonal _____
Marriage _____	Health _____	Family Members _____
Spiritual _____	Unfulfilled expectations ____	Other _____

Do you participate in any religious group? Are you an active participant?

_____
_____

Thank you for taking the time to fill out the requested information.
It will help greatly in our study of your present health concerns and will assist us
in choosing an appropriate direction for your restoration of health.