

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 prostate 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.

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.