Naturopathic Intake

Name ____ Date _______________

Date of birth ______________ (M/D/Y) Preferred Pronoun He☐ She☐ Other _____

Address: ______________________________________ Apt/unit # ____________

City __________________________ Province _______ Postal Code ___________

E-mail Address: ____

Telephone number:

Home: _______________ Work: _______________ Cell: _______________

May we leave messages relating to your visits? Yes☐ No☐

Which Phone Number ________________

Emergency contact:

Name: ___________________________________ Relation: ________________

Phone number(s): ________________________ or ________________________

How did you hear about our Clinic? ____________________________________

How would you identify your gender?

Women☐ Man☐ Non binary☐ Prefer to self-disclose☐

Other health care providers you are seeing:

Name: _________________________
Speciality: ______________________
Phone: _________________________
Date of Last Visit: _________________
(M/D/Y)

Name: _________________________
Speciality: ______________________
Phone: _________________________
Date of Last Visit: _________________
(M/D/Y)

Name: _________________________
Speciality: ______________________
Phone: _________________________
Date of Last Visit: _________________
(M/D/Y)

Name: _________________________
Speciality: ______________________
Phone: _________________________
Date of Last Visit: _________________
(M/D/Y)

Health Goals

What are your health concerns and goals, in order of importance to you:

Please list most important health concerns and goals in their order of significance	Prior diagnosis of this problem? If so, what?
1.	
2.	
3.	
4.	
5.	

Pregnancy:

Are you currently pregnant? Yes ☐ No ☐ Due date_______

Are you currently lactating? Yes ☐ No ☐

Medical history:

How would you describe your general state of health?
Excellent ☐ Good ☐ Fair ☐ Poor ☐

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.
1) ____
2) ____
3) ____
4) ____
5) ____
6) ____

Do you have any allergies (medicines, environmental, etc.)?
1) ____
2) ____
3) ____
4) ____
5) ____
6) ____

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) ____
2) ____
3) ____
4) ____
5) ____
6) ____

Please list **past** prescription medications/natural health products:

____
____
____
____

Please indicate Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers: ___________
Diet pills: ___________ Laxatives: ___________ Antacids: ___________
Birth control: ___________Type: ___________________
Antibiotics: ______________________________
Alcohol—how much/day or week____________________________________
Tobacco—form and amount/day ____________________________________
Caffeine—form and amount/day ____________________________________
Recreational drugs—what and how often______________________________

Please indicate what immunizations you have had:

☐DPT (diphtheria, pertussis, tetanus)
☐Haemophilus influenza B
☐Hepatitis A
☐Hepatitis B
☐"Flu"
☐MMR (measles, mumps, rubella)
☐Polio
☐Smallpox
☐Tetanus booster; when? ________________________

Other ____

Please indicate if any caused adverse reactions:

____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)?

☐ Yes ☐ No Last time you had blood work done *(M/D/Y)*_________________

Personal and Family History

Please place a "**Y**" in the "**yes**" box next to each condition that applies to you and/or one of your family members. Please indicate all who the condition applies to: "**Self**" if it relates to

you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please indicate **Past** if the condition is resolved, or **Current** if it is on-going and current.

Conditions	Yes (Y)	Relation (F), (M), (S), (G), (C)	Past (P) or Current Condition (CC)
Alcoholism/Drug Addiction			
Allergies			
Anemia			
Arthritis			
Asthma			
Cancer *(indicate type)*			
Diabetes			
Eczema			
Epilepsy			
Depression/ Other Mental Illness			
High Blood Pressure			
Heart Disease			
Hepatitis			
Headaches			
Kidney Disease			
Stroke			
Tuberculosis			
Osteoporosis			
Others:			

☐ I don't know my family medical history

Diet

Do you have any food allergies, sensitivities or intolerances? Please list.

1) ________________________________ 4)________________________________
2) ________________________________ 5) ________________________________
3) ________________________________ 6) ________________________________

Do you have any dietary restrictions (religious, vegetarian/vegan, dairy-free, etc.)?
____

24 Hour Diet Recall

Based on a typical day, what do you eat during the following times?

Breakfast____
Lunch____
Dinner____
Snacks____

Water____
Caffeine____
Juice____
Wine/Alcohol____
Other ____

Sleep

Bedtime:_________________________Wake-up Time:___________________________

Average hours of sleep per night:____

Times you wake up during the night:____

Quality of sleep (good, okay, poor): ____

Do you experience any Dreams/Nightmares? If so, describe:
____
____

Exercise

Do you exercise regularly?____
What type of exercise?____
How long?____
How often (times per week)?____

Environment

Occupation____

Hobbies____

Are you exposed to significant tobacco smoke (work, home, etc.)? ___________________

Are you frequently exposed to animals (Yes/No)? __________________________________

What types (work, pets, etc.)?____

How is your home heated?____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes, pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

____

____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)?

____

How would you describe the emotional climate of your home?

____

____

____

Stress:

On a scale of 1 to 10, what is your stress level? Circle the one that applies to you

(1 being no stress at all, 10 being extreme stress)

1 2 3 4 5 6 7 8 9 10

What is/are your source(s) of stress?

____

____

____

How do you cope with stress? What are your strategies?

____

____

____

Other:

Is there anything that you feel is important that has not been covered?

____

____

____