NATUROPATHIC INTAKE FORM

Today's Date: _________________

An accurate health history is important to ensure safe and effective treatment. However, if there are questions that you would rather not answer, or prefer to discuss in person feel free to do so.

Name:_____________________________________ Email: ___________________________________
Address: ____ Postal code:____________
Phone: (home) ____________________________ (work) ______________________________________
Date of birth: ________________ Age: ________ Occupation: ________________________________
Emergency contact: ______________________ Relation: ______________ Phone #: ________________
____

What aspect of your health would you like to focus on?
Health promotion _____ Acute condition _______________ Chronic condition _____________________
Other ____
Referred by? __________________________ Family Medical Doctor ___________________________

If you marked condition, how long have you had this? ____
Who diagnosed this?___________________________ When? _____________________________________
Specialists seen (and when) ____
____
How has this been treated until now?____
____

What are your health goals (*any specific areas or other conditions you would like to address*)?
1. ____
2. ____
3. ____
4. ____
5. ____
6. ____
7. ____
8. ____

Do you feel well? Yes _____ No _____ If no, how long has this been the case? _________________

Are you currently seeing any other health care practitioners?
Chiropractor ___ Massage Therapist ___ Psychotherapist ___ Other ? _______________________
(names: ____)

List all food supplements you are presently taking. Indicate the total dosage taken in one day. (i.e. if you take 2 tablets of vitamin C 500mg/day Total daily is 1000mg)
____
____
____
____
____
____

Medications:

List all prescribed medications *being* taken (*Indicate drug, dosage, frequency and how long you've been taking it)*

____
____
____

List all prescribed medications you've taken in the *Past* for any period longer than three months

____
____
____

How many courses of antibiotics have you had in the past 10 years? ______________________________

Have you had any bad reactions to antibiotics Yes ________ (*describe below*) No _______________

List any medications you have had a bad reaction to in the past, when it was, and what the reaction was:

____
____
____

Have you had a severe reaction from a vaccination? Yes ________ No _________ (If yes, explain vaccination type, when it was administered and the reaction)

____
____

List any over the counter medications you take, (*i.e. Aspirin, Tums etc*.) Indicate whether you take it rarely, occasionally, frequently or daily.

____
____
____

Do you use recreational drugs (i.e. marijuana)? Yes __________ No ____________
(if yes indicate type and frequency of usage)

____
____

Have you used recreational drugs in the past? Yes _________ No ___________

____

Health History:

Check any of the following conditions you have had, Please star those you still experience

Measles_________________	**Gallstones ____________**	**Bowel Disease _________**	**Mumps ____________**
High blood pressure ______	**Hives ________________**	**Scarlet Fever __________**	**Pleurisy ____________**
Whooping cough _________	**Malaria ______________**	**Arthritis ______________**	**Pneumonia __________**
Croup _________________	**Parasites _____________**	**Rheumatism ___________**	**Tuberculosis _________**
Asthma ________________	**Diarrhea _____________**	**Gout ________________**	**Genital herpes ________**
Eczema ________________	**Constipation _________**	**Kidney stones __________**	**Gonorrhea ___________**
Allergies _______________	**IBS ________________**	**Hypoglycemia __________**	**Chlamydia ___________**
Hay fever _______________	**Candida ____________**	**Depression _____________**	**Shigella ______________**
Sinusitis (chronic) ________	**Mononucleosis _______**	**Anxiety ________________**	**Influenza _____________**
Swollen glands ___________	**Cancer ______________**	**Ear infection ___________**	**Chicken pox ___________**
Diphtheria ______________	**Migraines____________**	**Endometriosis __________**	**Thyroid disorder _______**
Bronchitis ______________	**Eating disorder _______**	**Liver problems _________**	

Other: ____

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

____
____

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, when and where it was performed.

____
____
____

Accidents: Please indicate severity, injuries sustained, when it occurred, and any treatment required.

____
____
____

Family History:

Please indicate the age of all relatives living and indicate the age at which any family member became deceased (L= Living, D= Deceased).

Mother L ________ D ________ Father L ________ D ________
Sisters L ________ D ________ Brothers L ________ D ________
L ________ D ________ L ________ D ________

Indicate if there have been any of the following diseases in your Grandparents, parents or brothers and sisters. Indicate the number of relatives who have/had the disease.

Diabetes ________ Cancer ________ Heart disease ________ Stroke ________
Mental illness ________ Alzheimer's disease ________
Tuberculosis ________ Arthritis ________ Hypertension (high blood pressure) _______
Rheumatism________ Allergies ________ Thyroid problems ________
Kidney disease ________ Stomach disorders ________
If not already mentioned, is there a family history of your chief health concern? ___________

Additional personal history:

IF FEMALE

Age menstruation started ________ Age it stopped (i.e. menopause) ________
Are your periods regular? ________ Irregular ________ Approximate length of cycle (e.g. 28 days) ________
Do you experience PMS symptoms? Yes ________ No ________
If yes, what do you experience? ____
____

Do you have: Fibrocystic breasts? Yes ____ No ____ Uterine fibroids? Yes ____ No ____
Do you have recurring vaginal infections? Never ____ Rarely ____ Frequently ____ More than 3x/yr ____
How often do you experience cystitis? (bladder infection) Never ___ Rarely ___ Frequently ___ More than 3x/yr ____
Number of children ______________ Ages ______________________
Number of pregnancies ___________ Deliveries _________________
Miscarriages ____________________ Abortions _________________

Any complications associated with the above? ____
____

Lifestyle:

How many cups/bottles/glasses do you drink on the average per day?
Coffee _____ Tea _____ Water _____ Milk (2%) _____ Milk (skim) _____ Fruit juice _____
Soft drinks (diet) _____ Soft drinks (reg.) _____ Vegetable juice _____ Herbal tea _____
Beer _____ Wine _____ Liquor _____

Are you a vegetarian? ________ Vegan? __________ On a particular diet? ____________________

Do you smoke? No _____ Yes _____ (How many cigarettes ____? Cigars? ____ for how long _____)
Have you ever smoked? No _____ Yes _____ (for how long _____)
Does anyone smoke in your: Household? Yes ____ No ____ Workplace? Yes ____ No ____
How often do you have an alcoholic beverage? ____

How many hours of sleep do you get on the average? ____
Do you have any trouble: Falling asleep? Yes _____ No _____ Staying asleep? Yes _____ No _____

How many hours do you work each day? ____

What do you do for exercise? (Indicate type, frequency, and length of time on each occasion).
____
____
____

Have you had any dramatic changes in your weight in the last 10 years? ___________________________

When was your last vacation? ____
What do you do for recreation? ____
____
____

What level of personal stress are you experiencing right now?
Minimal ______ Average ______ Considerable ______ Unbearable ______

Which are the main stressors? Financial ______ Job related ______ Interpersonal ______ Marriage ______
Health ______ Unfulfilled expectations ______ Family members ______ Spiritual ______ Other: ______________________

Do you have a community/social network/spiritual or religious discipline that you can rely on for strength or support? ____

Is there anything you think I should know that hasn't been covered in this intake form? ________________
____
____

Thank you for taking the time to complete this form. It will help greatly in our study of your present health and will assist in choosing an appropriate direction to take in working toward your optimal health.