

***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)

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

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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:

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

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

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

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Have you used recreational drugs in the past? Yes \_\_\_\_\_ No \_\_\_\_\_

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**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 _____    |

## The Clinic Upstairs

Jan Dorrell B.Sc. N.D.

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Diphtheria \_\_\_\_\_ Migraines \_\_\_\_\_ 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 and when 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:**

MALE

Do you have any difficulty voiding (urinating) completely? \_\_\_\_\_

How often do you get up to go to the bathroom at night? \_\_\_\_\_

Have you been diagnosed with a prostate problem? \_\_\_\_\_

Do you have difficulty getting and maintaining erections? \_\_\_\_\_

Do you have difficulty with premature ejaculation while having intercourse? \_\_\_\_\_

Do you have any other problems concerning sexual health? \_\_\_\_\_

Do you have any children? \_\_\_\_\_ (names, ages)

**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).

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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? \_\_\_\_\_

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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? \_\_\_\_\_

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*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.*