ADULT INTAKE

Name: ____Date: ___________________

Address: ____

City: _______________________________ Prov: _____________ PC: ___________________

Telephone (home): ___________________________ (work): ____________________________

Age: _______ Date of Birth: ___________________________ Gender: Female / Male

Married:____ Separated:____ Divorced:____ Widowed:____ Single:____ Partnership:_____

Live with: Spouse:____ Partner:____ Parents:____ Children:____ Friends:____ Alone:____

Occupation: ____Hours per week: ________

Is this your first visit to a Naturopathic Doctor? ❒ Yes ❒ No

Are you under the care of any specialists? ❒ Yes ❒ No

____

(Name) (Specialty) (City)

How did you hear about this clinic? ____

Has any other family member already been a patient at this clinic? ______________________

Emergency contact: ______________________________ Relationship: _________________

Day Phone: _______________________ Eve Phone _______________________________

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally, and emotionally. The nature of your response to the following questions will go a long way in assisting my understanding of your health goals. Your time, thoughtfulness and honesty in completing this overview will greatly aid me to assist your health needs.

Why did you choose to come to this clinic?

CONTEXT OF CARE REVIEW CONTINUED

What do you know about our approach?

What *three* expectations do you have from *this* visit to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed.

0% 0 1 2 3 4 5 6 7 8 9 10 100%

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive?

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which we will be sharing with you?

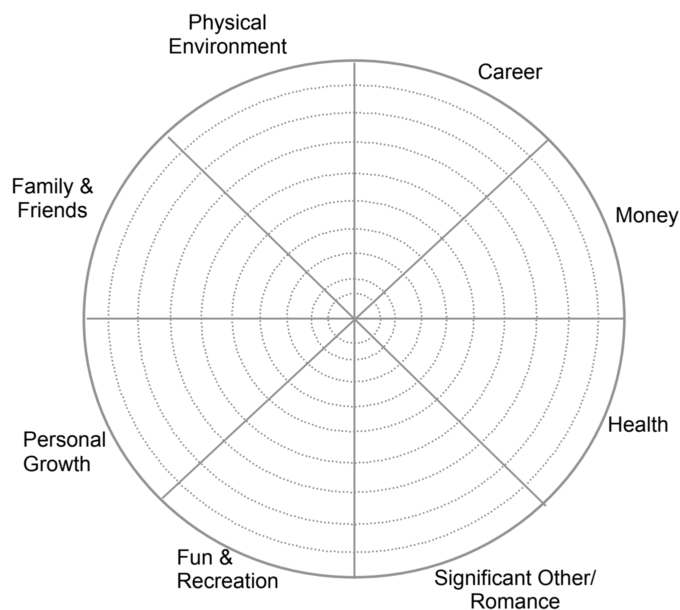
Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

What do you love to do?

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.
For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



What are your most important health problems?
List as many as you can in order of importance.

1) ______________________________

2) ______________________________

3) ______________________________

4) ______________________________

5) ______________________________

6) ______________________________

7) ______________________________

8) ______________________________

9) ______________________________

10) ______________________________

FAMILY HISTORY
Do you or anyone in your family have a history of any of the following? (please circle and say who)

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anemia	Mental Illness
Asthma	Hay fever	Hives	

Any other relevant family history? ____

What is your family heritage? ____

CHILDHOOD ILLNESSES
Please circle whether you had any of the following as a child:

Rheumatic fever	Diptheria	Scarlet fever	Chicken pox
German Measles	Measles	Mumps	

HOSPITALIZATIONS/SURGERY/IMAGING
What hospitalizations, surgeries, x-rays, CAT scans, EEG, EKGs have you had?

________________________year ________ ____________________ year _____

________________________year ________ ____________________ year _____

________________________year _________ ____________________year _____

ALLERGIES
Are you hypersensitive or allergic to:

Any drugs?____

Any foods?____

Any environmentals or chemicals?_______________________________________

CURRENT MEDICATIONS
Do you take or use any of the following (please circle):

Laxatives	Pain relievers	Antacids	Cortisone
Antibiotics	Tranquilizers	Sleeping Pills	Thyroid Medication
Birth Control Pills	Hormone Replacement		

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking:

____

____

____

____

____

GENERAL

Height: __________ Weight: ___________Weight one year ago: _________________

Maximum Weight: _______________ When: _________________________________

When during the day is your energy the best? ___________ Worst? ________________

Main interests and hobbies: ____

Exercise: Y / N If so, what kind and how often: ________________________________

Watch TV: Y / N If so, how many hours? _____ Read: Y / N If so, how many hours? ____

TYPICAL FOOD INTAKE

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

How many cups or glasses do you drink on average per day of the following:

Coffee________ Black Tea_______ Herbal tea _______Water_______ Milk 2%_______

Skim Milk ______Fruit Juice ______ Soft Drinks (diet) _____ Soft Drinks (reg)_______

Vegetable Juice_______ Beer_______ Wine_______ Liquor_______

What is the source of your drinking water?

__ Tap (city) __ Well __*Bottled (spring)* __ Filtered __ Distilled

FOR THE FOLLOWING, PLEASE CIRCLE:
Y = a condition you have now **N** = never had **P** = a significant problem in the past

GENERAL
Do you sleep well? Y N P
Average 6-8 hours? Y N P
Awake rested? Y N P
Have a supportive relationship? Y N P
Have a history of abuse? Y N P
Experienced a major trauma? Y N P
Use recreational drugs? Y N P
Treated for drug dependence? Y N P
Use alcoholic beverages? Y N P
Use tobacco? Y N P
Age start? _______
Age stop? __________
Do you enjoy your work? Y N P
Take vacations? Y N
Spend time outside? Y N P
Eat three meals a day? Y N P
Do you go on diets often? Y N P
Do you eat out often? Y N P
Do you drink coffee? Y N P
Drink black/green tea? Y N P
Drink soda/pop? Y N P
Do you eat refined sugar? Y N P
Do you add salt to your food? Y N P

SKIN
Rashes? Y N P
Eczema? Y N P
Psoriasis? Y N P
Hives? Y N P
Acne/boils? Y N P
Change in skin color? Y N P
Lumps or bumps on skin? Y N P
Itching? Y N P
Dryness? Y N P
Hair loss? Y N P
Night sweats? Y N P

EYES
Impaired vision? Y N P
Cataracts? Y N P
Glaucoma? Y N P
Spots in vision? Y N P
Color blindness? Y N P
Tearing or dryness? Y N P
Eye pain or strain? Y N P
Double vision? Y N P
Redness? Y N P
Light sensitive? Y N P
Discharge? Y N P

EARS
Impaired hearing? Y N P
Ringing in ears? Y N P
Dizziness? Y N P
Infection? Y N P
Ear aches? Y N P
Excess wax? Y N P

HEAD AND NECK
Headaches? Y N P
Migraines? Y N P
Head injury? Y N P
Jaw or TMJ problems? Y N P
Lumps in neck? Y N P
Goiter? Y N P
Pain or stiffness in neck? Y N P

NOSE AND SINUS
Frequent colds? Y N P
Stuffiness? Y N P
Sinus problems? Y N P
Nose bleeds? Y N P
Allergies? Y N P
Loss of smell? Y N P
Gum problems? Y N P

MOUTH AND THROAT
Frequent sore throat? Y N P
Copious saliva? Y N P
Sore tongue or lips? Y N P
Hoarseness? Y N P
Jaw clicks? Y N P
Teeth grinding? Y N P
Dental cavities? Y N P
Gum problems? Y N P
Sores? Y N P
Loss of taste? Y N P

RESPIRATORY
Cough? Y N P
Sputum? Y N P
Asthma? Y N P
Wheezing? Y N P
Bronchitis? Y N P
Coughing up blood? Y N P
Pneumonia? Y N P
Pleurisy? Y N P
Difficulty breathing? Y N P
Shortness of breath? Y N P
Shortness of breath when lying? Y N P
Pain on breathing? Y N P
Emphysema? Y N P
Tuberculosis? Y N P

CARDIOVASCULAR
Heart disease? Y N P
Angina? Y N P
High/Low blood pressure? Y N P
Heart murmurs? Y N P
Blood clots? Y N P

Fainting? Y N P
Phlebitis? Y N P
Palpitations/fluttering heart? Y N P
Rheumatic fever? Y N P
Chest pain? Y N P
Swelling in ankles? Y N P

GASTROINTESTINAL
Trouble swallowing? Y N P
Change in thirst? Y N P
Change in appetite? Y N P
Nausea/vomiting? Y N P
Ulcer? Y N P
Jaundice? Y N P
Gall bladder disease? Y N P
Liver disease? Y N P
Hemorrhoids? Y N P
Pancreatitis? Y N P
Heartburn? Y N P
Abdominal pain or cramps? Y N P
Belching or passing gas? Y N P
Constipation? Y N P
Bowel movements: how often? _______
Is this a change? Y N
Black stools? Y N P
Blood in stools? Y N P

URINARY
Increased freq. of urination? Y N P
Inability to hold urine? Y N P
Pain on urination? Y N P
Frequency at night? Y N P
Frequent urinary infections? Y N P
Kidney stones? Y N P
Reduced flow? Y N P

MUSCULOSKELETAL
Joint pain or stiffness? Y N P
Arthritis? Y N P
Broken bones? Y N P
Weakness? Y N P
Muscle spasms or cramps? Y N P
Sciatica? Y N P
Back pain? Y N P

BLOOD
Anemia? Y N P
Easy bleeding or bruising? Y N P
Cold hands/feet? Y N P
Deep leg pain? Y N P
Thrombophlebitis? Y N P
Varicose veins? Y N P

ENDOCRINE
Hypothyroid? Y N P
Hyperthyroid? Y N P
Hypoglycemia? Y N P
Excessive thirst? Y N P
Fatigue? Y N P
Heat or cold intolerance? Y N P
Diabetes? Y N P
Excessive hunger? Y N P
Seasonal depression? Y N P
Difficulty exercising? Y N P

IMMUNE
Reactions to immunizations? Y N P
Chronically swollen glands? Y N P
Slow wound healing? Y N P
Chronic fatigue syndrome? Y N P
Chronic infections? Y N P

NEUROLOGIC
Seizures? Y N P
Muscle weakness? Y N P
Loss of memory? Y N P
Vertigo or dizziness? Y N P
Paralysis? Y N P
Numbness or tingling? Y N P
Easily stressed? Y N P
Loss of balance? Y N P

MENTAL/EMOTIONAL
Treated for emotional prob? Y N P
Depression? Y N P
Anxiety or nervousness? Y N P
Poor concentration? Y N P
Do you have mood swings? Y N P
Tension? Y N P
Memory problems? Y N P
Phobias? Y N P

FEMALE REPRODUCTIVE
Age of first menses: _______________
Age of last menses if menopausal: _______
Length of cycle: __________ days
Duration of flow:__________ days
Are your cycles regular? Y N P
Painful menses? Y N P
Heavy or excessive flow? Y N P
PMS? Y N P
PMS Symptoms:
Depression Y N P
Irritability Y N P
Bloating Y N P
Increased appetite Y N P
Weight gain Y N P
Breast tenderness Y N P
Other________________

Bleeding between cycles? Y N P
Clotting? Y N P
Endometriosis? Y N P
Ovarian cysts? Y N P
Vaginal odor? Y N P
Vaginal discharge? Y N P
Date of last pap smear: ____________
Abnormal PAP? Y N P
Cervical dysplasia? Y N P
Are you sexually active? Y N P
Birth control? Type: _______________
Pain during intercourse? Y N P
Herpes? Y N P
Chlamydia? Y N P
Genital warts? Y N P
Syphilis? Y N P
Difficulty conceiving? Y N P
Number of pregnancies: ___________
Number of live births: _____________
Number of miscarriages: ___________
Number of abortions: _____________
Do you do self breast exams? Y N P
Breast pain/tenderness? Y N P
Breast lumps? Y N P
Nipple discharge? Y N P
Menopausal symptoms? Y N P

MALE REPRODUCTIVE
Are you sexually active? Y N P
Discharge or sores? Y N P
Chlamydia? Y N P
Genital warts? Y N P
Gonorrhea? Y N P
Herpes? Y N P
Syphilis? Y N P
Hernias? Y N P
Testicular masses? Y N P
Testicular pain? Y N P
Prostate disease? Y N P
Impotence? Y N P
Premature ejaculation? Y N P
Number of children:__________

Thank you for your time and effort. We look forward to providing you with the best possible care. If there is anything else you would like to add at this time please do so on the back of this page.