Poonam Patel, BSc, ND
Doctors of Naturopathic Medicine

ADULT INTAKE FORM

Please print clearly and fill out this form to the best of your ability. It will help to assess your present health and will assist in facilitating the healing process.

Date: ______________________________

Name: __________________________________ D.O.B. _____________________

Age: _________________________________ Gender: Male/Female

Present weight: ________________________ Present height: _________________________

Ethnicity: ______________________________

Marital Status: (circle one) married / separated / divorced / widowed / single / other: ________

Occupation: ___________________________ (circle one) full time / part time / retired / student

Emergency Contact:

Name: ______________________ Relation: ________________ Phone: (_____)_____________

Name: ______________________ Relation: ________________ Phone: (_____)_____________

How did you hear about our Clinic? ____

Referred by: ____

Names of other health care practitioners (medical doctor, chiropractor, specialists, physiotherapists, etc.) you are seeing:

Name: ______________________	Name: ______________________	Name: ______________________
Practitioner: _________________	Practitioner: _________________	Practitioner: _________________
Address: ____________________	Address: ____________________	Address: ____________________
____________________________	____________________________	____________________________
Phone: (_____)________________	Phone: (_____)________________	Phone: (_____)________________

CHIEF HEALTH CONCERNS:

List your health concerns in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____

MEDICAL HISTORY:

Describe your present general state of health: ____________________

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations (provide approximate dates):

1. ____________________
2. ____________________
3. ____________________
4. ____________________
5. ____________________

List any allergies (medicines, environmental, etc.) you have: ____________________

____

List all names of *prescribed medication* currently being taken. Include dosage, frequency, how long you have been taking it, and any adverse reactions/allergies to medications:

Medication	Dose (i.e. mg)	Frequency (#times/day)	Since How Long	Adverse Reactions Allergies (Describe)

List all *over the counter medication* that you take (e.g.: Aspirin, Tylenol, Tums, etc.). Include dosage and frequency and any adverse reactions/allergies to medications:

1. ____________________
2. ____________________
3. ____________________

List all vitamins, minerals, botanical (herbal) medicines, Asian medicines (Chinese Patent drugs), or homeopathic remedies that you are currently taking. Indicate daily dosage:

1. ____________________
2. ____________________
3. ____________________

Do you use any recreational drugs? Y/N (If yes, indicate what type and frequency of usage):

____

Indicate the vaccinations have you received:

- ❑Chicken pox (Varicella)
- ❑Cholera
- ❑DTP (Diphtheria/Tetanus/Pertussis)
- ❑Hepatitis A
- ❑Hepatitis B
- ❑Influenza (flu shot)
- ❑Influenza (flu shot)
- ❑MMR (Measles/Mumps/Rubella)
- ❑Meningococcal (meningitis)
- ❑Pneumococcal
- ❑Polio
- ❑Travel Vaccinations
- ❑Rabies
- ❑Rabies
- ❑Typhoid
- ❑BCG (Tuberculosis)
- ❑Yellow Fever
- ❑Don't know

Have you ever experienced any adverse reactions to the above vaccinations? Y/N (Describe): __________

____

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PREVIOUS HEALTH HISTORY/FAMILY HISTORY:

Check mark if you or any of your family members indicated has/had any of the following diseases. Circle L = Living or D = Deceased, and fill in the age.

Condition	YOU	Mother (L/D) age:	Father (L/D) age:	Grandmother (maternal) (L/D) age:	Grandfather (maternal) (L/D) age:	Grandmother (paternal) (L/D) age:	Grandfather (paternal) (L/D) age:
Alcoholism							
Allergies (to what?)							
Arthritis (type ?)							
Asthma							
Cancer (type ?)							
Cholesterol							
Diabetes							
Depression							
Drug Abuse							
Gallstones							
Heart disease							
High Blood Pressure							
Kidney disease							
Liver disease							
Mental Illness							
Stroke							
Thyroid (hyper/hypo)							
Other:							

List diseases/conditions that apply to your siblings

Sister: ______________________ Brother: ______________________
Sister: ______________________ Brother: ______________________
Sister: ______________________ Brother: ______________________

- o I don't know my family history

LIFESTYLE:

What did you eat/drink in the past 24 hours, for:

Breakfast: ______________________
Lunch: ______________________
Dinner: ______________________
Snacks: ______________________
Beverages: ______________________

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? Y/N

If yes, describe: ______________________

Do you drink alcohol? Y/N (If yes, indicate what type of alcohol and how many glasses per week):

____

Do you smoke? Y/N (If yes, indicate for how long, and how many cigarettes/cigars per day):

____

Does anyone else in your household smoke? Y/N

Do you own any pets? Y/N (Indicate what type): ______________________________
On average how many hours of sleep do you get a day? ______________________________
How many hours do you work each day? ______________________________
Do you exercise? Y /N (Indicate what type of exercise and how long): ______________________________
____
List your hobbies: ______________________________
Are you sexually active? Y / N Method of contraception: ______________________________
If you are a female are you: Pregnant? Y/N or Lactating? Y/N
What level of personal stress are you experiencing at the present moment? (circle one):
minimal/average/considerable/unbearable
What is/are your major stressor(s)?

- ❑financial
- ❑personal health
- ❑interpersonal
- ❑job related
- ❑family members
- ❑spiritual
- ❑marriage
- ❑family issues (i.e. death)
- ❑other: ______________________________

REVIEW OF SYSTEMS:

Please **circle** the condition if you have it **presently** or <u>underline</u> it if you have had it in the <u>past</u>:

- **Skin** – rashes, eczema, psoriasis, acne, itching, lumps, colour change, dry, moist, easy bruising
- **Nails** – colour changes, fungal infections, brittle/shear, vertical/horizontal lines, hangnails
- **Head** – migraines, headaches, dizziness
- **Eyes** – corrected vision, pain, tearing, dryness, blurring, redness, discharge, itching, cataracts, glaucoma
- **Ears** – impaired hearing, earache, discharge, infections
- **Nose & Sinus** – frequent colds, nose bleeds, stuffiness, hay fever, sinus problems
- **Mouth & Throat** – frequent sore throat, gum problems, hoarseness, dental cavities, loss of taste
- **Neck** – lumps, swollen glands, pain/stiffness, enlarged thyroid
- **Lungs** – cough, phlegm, spitting up blood, wheezing, difficulty breathing or shortness of breath, pain on breathing, asthma, bronchitis, tuberculosis, pneumonia
- **Cardiovascular** – heart disease, high blood pressure, murmurs, palpitations, chest pain
- **Peripheral vascular** – deep leg pain, cold extremities, varicose veins, swollen arms/legs, ulcers
- **Gastrointestinal** – heartburn, indigestion, nausea, vomiting, belching, passing gas, stomach pain
- **Gastrointestinal** – constipation, diarrhea, blood in stool, mucous in stool, hemorrhoids, black stool
- **Urinary** – pain, frequent urination, inability to hold urine, blood in urine, urgency, infections, kidney stones
- **Musculoskeletal** – joint pain/stiffness/swelling, muscle pain/stiffness/weakness/cramps, back pain, broken bones
- **Neurologic** – fainting, seizures, paralysis, numbness/tingling
- **Neurologic** – loss of balance, involuntary movement, speech problems, memory loss
- **Endocrine** – fatigue, heat/cold intolerance, thyroid problems, excess thirst/hunger/sweating
- **Women's health** – fibrocystic breasts, breast lumps, breast tenderness, nipple discharge
- **Women's health** – painful periods, PMS, excessive menstrual flow, irregular periods
- **Women's health** – vaginal discharge, vaginal itching, painful/difficult intercourse, hernias, STDs
- **Men's health** –testicular masses/pain, discharge from penis, difficult intercourse, hernias, STDs
- **Emotional** – mood swings, anxiety/nervousness, insomnia
- **Exposure** to pest, tobacco smoke, toxins/chemicals at work or home
- **Date of last physical exam:** ______________________________