NATUROPATHIC ADULT INTAKE FORM

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GENERAL

Name:		Date of 1st Visit :
Date of Birth :	Age:	Gender: M F
Address:		
City:	Prov:	Postal Code:
Phone (home):	Phone (work):	
Phone (cell):	Email:	
Occupation:	Hours worked per week:	
Marital Status: ❑ Single ❑ Common-law ❑ Same-Sex ❑ Married ❑ Separated ❑ Divorced ❑ Widowed		
Live with (check all that apply): ❑ Spouse ❑ Partner ❑ Parents ❑ Children ❑ Friends ❑ Alone		
Number of Children:	Ages & Gender of children:	

EMERGENCY CONTACT

Name:	Relationship:
Phone (home):	(work/cell):

OTHER HEALTH CARE PROVIDERS

1.	2.
Phone:	Phone:
Fax:	Fax:
3.	4.
Phone:	Phone:
Fax:	Fax:

Do you have regular screening tests done by another doctor? (Pap, annual physical, bloodwork, etc) ❑ yes ❑ no

Date of last physical exam: ____

How did you hear about our clinic? ____

HEALTH CONCERNS

Reason for visit (list in order of importance):

____
____
____
____
____

How long have you had this condition:

____
____
____
____
____

What type of therapies have you tried in the past for these concern(s)?

❑ Diet Modification ❑ Vitamins/minerals ❑ Detoxification ❑ Herbs ❑ Homeopathy ❑ Chiropractic
❑ Acupuncture ❑ Pharmaceuticals ❑ Other _______________

What was the outcome? ____

FAMILY HISTORY

Please check any the following that a family member has experienced:

- ❑ Arthritis
- ❑ Asthma
- ❑ Alzheimer's Disease
- ❑ Autoimmune (MS, Lupus, etc)
- ❑ Cancer
- ❑ Depression
- ❑ Diabetes
- ❑ Eczema
- ❑ Drug Addiction/Alcoholism
- ❑ Heart disease
- ❑ High Blood Pressure
- ❑ Migraine headaches
- ❑ Psoriasis
- ❑ Kidney Disease
- ❑ Stroke
- ❑ Thyroid Issues
- ❑ Mental Illness
- ❑ Other _________________

HEALTH HISTORY

How would you rate your general current state of health on the following scale:
1 2 3 4 5 6 7 8 9 10

Current prescription(s) and/or over the counter medication(s):

____
____

Current supplements and/or vitamins:

____
____

Major Hospitalizations, Surgeries, and Injuries: please indicate dates and complications (if any)

Year Illness, Surgery, Injury, Major Medical Diagnosis

__________ ____
__________ ____
__________ ____

Do you have any allergies (foods, medications, environmental, etc.)

___

___

Do you frequently use any of the following:

❑ Aspirin	❑ Antacids	❑ Birth control
❑ Laxatives	❑ Diet pills	❑ Tylenol/Advil/Ibuprofren
❑ Alcohol	Type and amount per day/week:	
❑ Tobacco	Form and amount/day:	
❑ Caffeine	Form and amount/day	
❑ Recreational drugs	What and how often:	

Please check all of the following that apply to you:

EXERCISE

- ❑ No formal exercise
- ❑ 5-7 days per week
- ❑ 3-4 days per week
- ❑ 1-2 days per week
- ❑ 45 minutes or more duration per workout
- ❑ 30-45 minutes duration per workout
- ❑ less than 30 minutes duration per workout
- ❑ Walk
- ❑ Run, jog, jump rope
- ❑ Weight train
- ❑ Yoga
- ❑ Swim
- ❑ Other ___________

NUTRITION & DIET

- ❑ Mixed food diet (animal and vegetable)
- ❑ Vegetarian
- ❑ Vegan
- ❑ Salt restriction
- ❑ Fat Restriction
- ❑ Carbohydrate Restriction
- ❑ Religious restriction(s)
- ❑ Food intolerances
- ❑ Other ___________

FOOD FREQUENCY

- ❑ Skip Breakfast
- ❑ One meal per day
- ❑ Two meals per day
- ❑ Three meals per day
- ❑ Graze (small frequent meals)
- ❑ Eat constantly whether hungry or not
- ❑ Eat on the run
- ❑ Add salt to food

SLEEP

- ❑ Wake feeling rested
- ❑ Wake feeling tired
- ❑ 8-10 hours per night
- ❑ 6-8 hours per night
- ❑ Less than 6 hours per night
- ❑ Undisturbed sleep
- ❑ Difficulty falling asleep
- ❑ Difficulty staying asleep

Please rate your quality of sleep on the following scale (1 being the least):

1 2 3 4 5 6 7 8 9 10

Please rate your current stress level on the following scale (1 being the least):

1 2 3 4 5 6 7 8 9 10 Source: ___________

Do you consider yourself: ❑ Overweight ❑ Underweight ❑ Just right Your weight ________

Have you experienced any unintentional weight loss of 10 lbs or more over the last 3 months? ❑ Yes ❑ No

Are you exposed to any harmful chemicals (e.g. smoke, renovations, pesticides)? ❑ Yes ❑ No
If so, please describe. ___________

___

Is there anything else you feel is important to add:

___

___

___

PERSONAL OVERVIEW

Reversing illness by treating the underlying cause of disease, and effectively managing healthcare *does not happen overnight*. It requires a commitment to lifestyle change, and following therapeutic protocols.

What is the main condition or change you would like to see happen?

____

____

How long do you feel this will take? ______________________________

How would you describe your present level of commitment to making changes in your health? Please circle one of the following.

(%) 0 10 20 30 40 50 60 70 80 90 100

What behaviors or lifestyle habits do you currently engage in that you believe positively impact your health?

1. ______________________________
2. ______________________________
3. ______________________________

What behaviors or lifestyle habits do you currently engage in that you believe are detrimental to your health?

1. ______________________________
2. ______________________________
3. ______________________________

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health? Is there anything that will prevent you from adhering to the therapeutic protocols that I will be sharing with you?

1. ______________________________
2. ______________________________
3. ______________________________

Do you have people who will sincerely and consistently support you with the beneficial lifestyle changes you will be making? If so, whom? ______________________________

What expectations do you have of me as your Naturopathic Doctor?

____

____

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

1. ______________________________
2. ______________________________
3. ______________________________

What long term expectations do you have from working with an ND?

____

____

____

What do you love to do?

____

____

____

CONTEXT OF CARE

Please shade in the following diagram.

Each slice of the pie represents an aspect of your life. The divisions of each slice will represent your current level of happiness in each area. Each division represents 10% fulfillment of that area.