

NATUROPATHIC ADULT INTAKE FORM

225 MILITARY RD, PO BOX 516, LANCASTER, QC K0C 1N0
 PHONE 514.674.1674 EMAIL ND@INTEGRATIVEHEALTHCENTRE.CA
WWW.INTEGRATIVEHEALTHCENTRE.CA

GENERAL

Name:		Date of 1 st 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: <input type="checkbox"/> Single <input type="checkbox"/> Common-law <input type="checkbox"/> Same-Sex <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed			
Live with (check all that apply): <input type="checkbox"/> Spouse <input type="checkbox"/> Partner <input type="checkbox"/> Parents <input type="checkbox"/> Children <input type="checkbox"/> Friends <input type="checkbox"/> 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:

- | | | |
|--|--|---|
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Psoriasis |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Eczema | <input type="checkbox"/> Kidney Disease |
| <input type="checkbox"/> Alzheimer’s Disease | <input type="checkbox"/> Drug Addiction/Alcoholism | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Autoimmune (MS, Lupus, etc) | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Thyroid Issues |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Mental Illness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Migraine headaches | <input type="checkbox"/> 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:

<input type="checkbox"/> Aspirin	<input type="checkbox"/> Antacids	<input type="checkbox"/> Birth control
<input type="checkbox"/> Laxatives	<input type="checkbox"/> Diet pills	<input type="checkbox"/> Tylenol/Advil/Ibuprofen
<input type="checkbox"/> Alcohol	Type and amount per day/week:	
<input type="checkbox"/> Tobacco	Form and amount/day:	
<input type="checkbox"/> Caffeine	Form and amount/day	
<input type="checkbox"/> 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.

