

Naturopathic Intake

Name: _____ Date of Birth (M/D/Yr) _____

Address: _____

_____ Postal Code: _____

Phone (H): _____ (W): _____

Occupation: _____ Employer: _____

Sex: M/F: _____ Marital Status: _____ # of Children: _____

Contact person in case of emergency: _____ Tel. #: _____

Does your extended health care plan cover Naturopathic services? (Y/N) _____

Have you had previous Naturopathic services? (Y/N) _____ When: _____

Have you had previous Chiropractic services? (Y/N) _____ When: _____

Date of last medical visit: _____ Reason for visit: _____

Family

physician: _____

How did you hear about the clinic? _____

• Past injuries/traumatic events: _____ When: _____

• Past surgeries/hospitalizations: _____ When: _____

• Past vaccinations: _____ any reactions: _____

• Last prescription for antibiotics: _____ reason: _____

• Please list allergies (if any): _____

• Please list all currently used medications: _____

Supplements

• What kind of physical activity do you do? _____

Are there any conditions after which you have never been totally well again?

My primary purpose for seeking Naturopathic service is: _____

Please list in order of priority areas in which you would like improvement:

8. _____

9. _____

10. _____

Indicate which, if any, of the following conditions you have ever had:

Abscesses	_____	Gonorrhea	_____	Pleurisy	_____
ADD /ADHD	_____	Gout	_____	Pneumonia	_____
Alcoholism	_____	Hay Fever	_____	Premenstrual	_____
Allergies	_____	Heart Disease	_____	Syndrome	_____
Anemia	_____	Hepatitis	_____	Prostatitis	_____
Arthritis	_____	HIV	_____	Rheumatic fever	_____
Asthma	_____	Infertility	_____	Scarlet Fever	_____
Cancer	_____	Influenza	_____	Sexual abuse	_____
Cankers	_____	IBS	_____	Sinusitis	_____
Chicken pox	_____	Kidney Disease	_____	Stroke	_____
Chlamydia	_____	Leukemia	_____	Strep Throat	_____
Cold Sores	_____	Low/High Blood	_____	Syphilis	_____
Crohn's / Colitis	_____	Pressure	_____	Thyroid Disease	_____
Depression	_____	Lyme Disease	_____	Tonsillitis	_____
Diabetes	_____	Malaria	_____	Tuberculosis	_____
Emphysema	_____	Measles	_____	Typhoid Fever	_____
Endometriosis	_____	Miscarriage	_____	Uterine fibroids	_____
Epilepsy	_____	Mononucleosis	_____	Venereal Wart	_____
Fibrocystic Breasts	_____	MS	_____	Warts	_____
Frequent colds	_____	Mumps	_____	Whooping cough	_____
Fungal infections	_____	Parasites	_____	Worms	_____
Gallstones	_____	Peritonitis	_____	Yeast infections	_____
Genital Herpes	_____	Pelvis Inflammatory	_____		
		Disease	_____		

Any other conditions?

Is there any condition from which you have not fully recovered? Yes _____ No _____

If yes, provide details: _____

FAMILY HEALTH HISTORY

Indicate below which of the following ailments, or any other ailments, have affected your relatives:

Alcoholism	Asthma	Epilepsy	Heart Disease	Paralysis	Syphilis
Allergies	*Cancer	Gonorrhoea	Hypertension	Pneumonia	Thyroid
Alzheimer's	Depression	Gout	Kidney Disease	Skin disease	Disorder
Arthritis	Diabetes	Hay Fever	Mental Illness	Digestive Disorders	Tuberculosis

RELATIVE	AGE if alive	AGE at death	AILMENTS
Mother			
Father			
Brothers			
Sisters			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

* Please specify type of cancer (primary source) _____

REVIEW OF SYMPTOMS

Please circle "Y" if you have the condition now and "P" if you have had it in the past (persistently)

SKIN:

Rashes	Y	P
Hives	Y	P
Acne	Y	P
Boils	Y	P
Eczema	Y	P
Psoriasis	Y	P
Dry skin	Y	P
Itching	Y	P
Lumps	Y	P
Night sweats	Y	P
How often	_____	
Other	_____	

MOUTH & THROAT:

Hoarseness	Y	P
Gum problems	Y	P
Dental fillings	Y	P
Sores	Y	P
Mouth dryness	Y	P
Sore throats	Y	P
Lost taste	Y	P
Other	_____	

RESPIRATORY:

Wheezing	Y	P
Cough	Y	P
Breath short	Y	P
Difficult breath	Y	P
Chest pain	Y	P
Bloody sputum	Y	P
Emphysema	Y	P
Asthma	Y	P
Breath Painful	Y	P
Bronchitis	Y	P
Pneumonia	Y	P
Pleurisy	Y	P
Last chest ray	_____	
Last TB test	_____	
Other	_____	

GASTROINTESTINAL:

Heartburn	Y	P
Difficult swallow	Y	P
Thirst changes	Y	P
Appetite changes	Y	P
Nausea	Y	P
Indigestion	Y	P
Gas/belching	Y	P
Constipation	Y	P
Rectal bleeding	Y	P

Hemorrhoids	Y	P
Jaundice	Y	P
Hernias	Y	P
Diarrhea	Y	P
No. BM/day	_____	

HEAD:

Headache	Y	P
Migraine	Y	P
Dizziness	Y	P
Injuries	Y	P
Other	_____	

NECK:

Pain	Y	P
Swollen glands	Y	P
Lumps	Y	P
Goitre	Y	P
Stiffness	Y	P
Other	_____	

NOSE AND SINUSES:

Bleeding	Y	P
Stuffiness	Y	P
Hayfever	Y	P
Injury	Y	P
Colds	Y	P
Allergies	Y	P
Obstructions	Y	P
Sinus problems	Y	P
Other	_____	

CARDIOVASCULAR:

Heart disease	Y	P
Angina	Y	P
High blood pressure	Y	P
Murmurs	Y	P
Chest pain	Y	P
Palpitations	Y	P
Ankle swelling	Y	P
Rheumatic fever	Y	P
Last ECG test	_____	
Other	_____	

URINARY:

Pain urinating	Y	P
More frequent	Y	P
Reduced flow	Y	P
Kidney stones	Y	P
Blood in urine	Y	P

Infections	Y	P
Incontinence	Y	P
Other	_____	

EYES:

Impaired vision	Y	P
Pain	Y	P
Redness	Y	P
Double vision	Y	P
Cataracts	Y	P
Light sensitive	Y	P
Discharge	Y	P
Tearing	Y	P
Dryness	Y	P
Itching	Y	P
Blurring	Y	P
Glaucoma	Y	P
Blind spot(s)	Y	P
Contact lenses	Y	P
Other	_____	

EARS:

Discharge	Y	P
Itching	Y	P
Excess wax	Y	P
Infections	Y	P
Ringing	Y	P
Earache	Y	P
Hearing loss	Y	P
Other	_____	

BREASTS:

Lumps	Y	P
Tenderness	Y	P
Self examine?	Y	P
Other	_____	

PERIPHERAL VASCULAR:

Cold hands/feet	Y	P
Deep leg pain	Y	P
Varicose veins	Y	P
Thrombophlebitis	Y	P
Other	_____	

MUSCULOSKELETAL:

Joint pain	Y	P
Arthritis	Y	P
Broken bones	Y	P
Numbness	Y	P
Tingling	Y	P
Muscle spasms	Y	P
Weakness	Y	P
Backache	Y	P
Other		

FEMALES:

Age of first menses		
Menopause symptoms		
Age		
Type of birth control		
How long?		
Vaginal discharge	Y	P
Vaginal itching	Y	P
Decreased sexual desire	Y	P
Other		

MENSES:

Cycle regular	YES	NO
Length of cycle		
Bleeding between periods	Y	P
Painful menses	Y	P
Excessive flow	Y	P
No. of pregnancies		
Age		
No. of miscarriages		
No. of abortions		

PMS SYMPTOMS:

Depression	Y	P
Irritability	Y	P
Bloating	Y	P
Increased appetite	Y	P
Weight gain	Y	P
Breast tenderness	Y	P
Other		

REPRODUCTIVE:

Sexual difficulties	Y	P
Venereal disease	Y	P

MALE:

Prostate symptoms	Y	P
Impotence	Y	P
Testicular masses	Y	P
Hernia	Y	P
Urgency of urination	Y	P
Incomplete urination/ Dribbling	Y	P
Decreased sexual desire	Y	P

BLOOD/LYMPHATICS:

Anemia	Y	P
Swollen lymphs	Y	P
Easy bleeding	Y	P
Bruising	Y	P
Transfusions	Y	P
Clotting	Y	P
Other		

ENDOCRINE:

Thyroid problems	Y	P
Diabetes	Y	P
Hypoglycemia	Y	P
Hormone therapy	Y	P
Other		

NEUROLOGICAL:

Fainting	Y	P
Seizures	Y	P
Convulsions	Y	P
Paralysis	Y	P
Muscle weakness	Y	P
Memory loss	Y	P
Involuntary movements	Y	P
Loss of balance	Y	P
Speech problems	Y	P
Other		

PSYCHO/SOCIAL:

Depression	Y	P
Tension	Y	P
Mood swings	Y	P
Phobias	Y	P
Sleep problems	Y	P
Anxiety	Y	P
Nervousness	Y	P
Alcohol or drug abuse	Y	P
Other		

ADRENAL:

Fatigue, apathy	Y	P
Allergies	Y	P
Delayed wound healing	Y	P
Low blood pressure	Y	P
Dizziness when Standing up	Y	P
Frequent urination	Y	P
Muscular weakness	Y	P
Nervousness	Y	P
Low back pain	Y	P
Ringling in the ears	Y	P

THYROID:

Loss of hair	Y	P
Weight gain	Y	P
Dry skin	Y	P
Loss of outer part of Eyebrows	Y	P
Menstrual disorders	Y	P
Stubborn constipation	Y	P
Goiter	Y	P
Low or high blood Cholesterol	Y	P
Feeling very cold	Y	P

LIVER:

Anemia	Y	P
Hypertension	Y	P
Elevated blood Cholesterol	Y	P
Low energy before eating	Y	P
Decreased drug or Alcohol tolerance	Y	P
Premenstrual tension	Y	P
Endometriosis	Y	P
Heavy menses	Y	P
Frequent headaches	Y	P
Skin problems	Y	P
Constipation	Y	P
Gall bladder problems	Y	P
Chronic muscle tension	Y	P
Eye problems	Y	P
Difficulty digesting Fatty foods	Y	P

PANCREAS:

Food allergies	Y	P
Blood sugar Abnormalities	Y	P
Maldigestion	Y	P
Undigested food in stool	Y	P
Bowel gas	Y	P
Stool floats	Y	P

PARATHYROID:

Osteoporosis	Y	P
Joint pain	Y	P
Gum/tooth disease	Y	P
Kidney stones	Y	P
Ridged fingernails	Y	P

Indicate which, if any, of the following medications you are currently taking: ✓

anti-inflammatory/cortisone	_____	heart medications	_____
antacids	_____	laxatives	_____
antibiotic	_____	lithium	_____
antidiabetic/insulin	_____	oral contraceptives	_____
antidepressants	_____	radiation	_____
antifungal	_____	relaxants/sleeping pills	_____
aspirin/tylenol	_____	thyroid	_____
chemotherapy	_____	recreational drugs	_____
hormones	_____	ulcer medications	_____
high blood pressure	_____	other (specify) _____	_____

Indicate which, if any, of the following items you eat, drink or use: ✓

alcohol	_____	herbal teas	_____
aluminum pans	_____	luncheon meats	_____
candy	_____	margarine	_____
carbonated beverages	_____	microwave	_____
chew tobacco	_____	minerals	_____
cigarettes	_____	refined sugars	_____
coffee	_____	saccharine (sweet & low)	_____
distilled water	_____	spring water	_____
fast foods	_____	tea	_____
fried foods	_____	vitamins	_____

Indicate which, if any, of the following apply to you: ✓

Diet often	_____	Under excessive stress	_____
Do not exercise regularly	_____	Exposed to chemicals at work	_____
Salt food without tasting	_____	Exposed to cigarette smoke	_____

How much do you drink of the following items on a daily basis:

Beer	_____	Milk (2%)	_____
Coffee	_____	Soft Drinks (diet)	_____
Fruit juice	_____	Soft Drinks (reg.)	_____
Herbal tea	_____	Tea	_____
Liquor	_____	Water	_____
Milk (skim)	_____	Wine	_____

How often would you have an alcoholic beverage? _____

