Summit Naturopathic
Dr. Devin McEachern, ND
526 Bryne Dr, Barrie, ON
(705) 730.1533

ADULT INTAKE

Personal Information: Date:_____

Name:_____
(First) (Last)

Date of Birth (yyyy/mm/dd):_____ Gender: M / F

Address:_____

_____

Telephone(Home)_____(Work/Cell)_____

May the clinic leave voice mail messages relating to appointments? Yes No

Email:_____

Emergency contact name_____

Telephone_____Relationship:_____

How did you hear about the clinic?:_____

Other Health Care Providers (HCP):

Family Doctor:_____

Telephone_____Fax:_____

Other HCP:_____

Telephone_____Fax:_____

Other:_____

Telephone_____Fax:_____

Do we have permission to contact these practitioners Yes No

THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY. IT WILL BE KEPT IN THIS OFFICE AND STRICTLY CONFIDENTIAL UNLESS YOU AUTHORIZE US IN WRITING FOR IT TO BE RELEASED. PLEASE COMPLETE THIS FORM AS THOROUGHLY AS POSSIBLE.

Health History

What are you current health concerns in order of importance/severity to you?

1._____

2._____

3._____

4._____

5._____

If you are a female are you currently pregnant? Yes No

Are you planning to be pregnant ? Yes No

Please list all **current** medications/supplements you are taking: (name, dose, length taken)

_____

_____

_____

_____

_____

Please list all **past** medications/supplements: (name, dose, length taken)

_____

_____

_____

Please list any allergies or sensitivities you have: (food, medication, environmental)

_____

_____

_____

Please indicate any serious conditions, illnesses, or hospitalizations; along with approximate dates:

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

_____ Date:_____

Over the past 5 years, how many times have you been treated with antibiotics?_____

Please indicate any immunizations you have had;

___DPT (diptheria, pertussis, tetanus) ___Flu Vaccine ___Polio
___MMR (measles, mumps, rubella) ___Hepatitis A ___Hepatitis B
___Haemophilus Influenza B ___Gardasil (HPV Vaccine) ___Meningococcal

Other:_____

Please explain any adverse reactions experienced:_____

_____

Family Medical History:

Please indicate if any relative (parent, sibling, child, other) has had any of the following :

	Family member, Age		Family member, Age
Allergies		Other mental illness	
Asthma		Heart disease	
Arthritis		High blood pressure	
Cancer		Kidner disease	
Diabetes		Other	
Drug abuse		Other	
Depression		Other	

Personal Health:

Height:_____ Current Weight_____ Max Weight_____Year_____

When was your last physical exam?_____Specific reason?_____

Do you get regular SCREENING TESTS done by another doctor? (Pap, blood test, etc) YES NO

Please list:_____

How often do you use any of the following, and in what dose?

Aspirin		Pain killers	
Alcohol		Recreational drugs	
Caffeine		Tobacco (1st or 2nd hand)	
Diet pills		Antacids	
Hormone therapy		Birth Control Pill	
Laxatives		Other	

Dietary/Lifestyle Habits:

Do you have any dietary restrictions? (allergic, religious, vegetaria, vegan, etc.)

Please describe a typical day's diet (food and beverage intake)

Breakfast

Lunch

Dinner

Snacks

Beverages

Have you ever been on a specialized diet?

What is your occupation? How many hours/day?

What level of stress are you experiencing right now? (low) 1 2 3 4 5 6 7 8 9 10 (high)

What are the contributing stressors?

Do you sleep well? Yes No

If No, please describe:

How many hours do you sleep per night? Do you wake rested? YES NO

Do you wake up in the night? Yes No

If yes (how many times, and for what reason)

Do you exercise regularly? Yes No

If Yes, what type(s) and how often?

If there are any other health concerns, symptoms or comments you feel may be important to note, please use the space below.