New Roots THERAPY

Counselling & Wellness Services for Individuals, Couples, & Families

Adult Intake

Please complete this form and return to reception. Please print clearly.

Demographic Information

Name: _____ Date: _____ (MM/DD/YYYY)

Date of Birth: _____ (MM/DD/YYYY) Gender: M ☐ F ☐ Other: _____

Address: _____ Apt/Unit #: _____

City: _____ Province: _____ Postal Code: _____

Home: (____) _____ Work: (____) _____ Cell: (____) _____

May we leave messages relating to your visits? Y ☐ N ☐ Which Number: (____) _____

Emergency Contact Information

Emergency Contact Name(s): _____

Phone Number(s): (____) _____ OR: (____) _____ Relation: _____

How did you hear about us? _____

Have you ever consulted a complimentary health care practitioner? (please check all that apply)

☐ Naturopathic Doctor ☐ Acupuncturist ☐ Homeopath ☐ Nutritionist ☐ Counsellor ☐ Dietician

☐ Chinese Medicine Practitioner Other: _____

Other Health Care Providers That You See

Name: _____ Name: _____

Specialty: _____ Specialty: _____

Address: _____ Address: _____

Phone: (____) _____ Phone: (____) _____

Office: 213 Byron St South, Unit 203, Whitby, ON, L1N 4P7
E-mail: info@newrootstherapy.com | Phone: (905) 665-8150 | Fax: (289) 274-2833
Website: lisasmithnd.ca | newrootstherapy.com

What are your **health concerns**, **goals** and **expectations** for working with us? (in order of importance to you)

1._____

2._____

3._____

4._____

5._____

Medical History

Please indicate any **serious conditions**, **illnesses**, **injuries** and **hospitalizations** that you have experienced (with dates):

1._____

2._____

3._____

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

_____

_____

Do you get regular screening tests done by another doctor? (blood tests, paps, etc) Y☐ N☐ If so, when was the last time you had any blood work or imaging done and for what purpose?

_____

_____

Please list all current **medications** and **natural health products** (e.g. prescriptions, over the counter medications, vitamins, herbs, homeopathics, etc).

Medications and Natural Health Products	Dose	Reason for Taking

Please circle yes (Y), no (N) or past (P) regarding the use of the following:

Aspirin, Tylenol, Advil or other pain relievers: Y☐ N☐ P☐ Recreational drugs: Y☐ N☐ P☐

Laxatives: Y☐ N☐ P☐ Antacids: Y☐ N☐ P ☐ Diet pills: Y☐ N☐ P☐

Antibiotics: Y☐ N☐ P☐ Alcohol: Y☐ N☐ P☐ Tobacco: Y☐ N☐ P☐

Do you **exercise** regularly? Y☐ N☐ If so, what do you do, how much and how often?

How would you rate the **stress** in your life (0-10, 10=highest)? _____

What are the current sources of stress in your life and how do you cope with them?

Do you have any dietary restrictions (vegetarian, religious, etc)?: _____

How would you rate your average daily **energy** (0-10, 10=highest)? _____

Is there a time of day that you feel you have the most energy or the least energy?

Are you currently experiencing any of the following?

		If yes, please explain:
General (Night sweats, Unexplained Weight Loss/Gain, Fatigue, Insomnia)	Y / N	
Eyes/Head (Double Vision, Glaucoma, Vision Loss, Cataracts, Headache)	Y / N	
Ear/Nose/Mouth (Hearing Loss, Sinus Problems, Dizziness, Taste Changes)	Y / N	
Heart (Chest Pain, Irregular Heartbeats, Murmur, High Blood Pressure)	Y / N	
Respiratory (Shortness of Breath, Wheezing, Coughing)	Y / N	
GI (Heartburn, Diarrhea, Constipation, Vomiting, Abdominal Pain)	Y / N	
Urinary (Frequent or Painful Urination, Incontinence, Blood in Urine)	Y / N	
MSK (Aches, Arthritis, Swollen Joints, Gout, Cramps, Stiffness, Weakness)	Y / N	
Skin/Hair/Nails (Rashes, Excessive Dryness, Sores, Itching, Hair Loss)	Y / N	
Neurological (Numbness, Tingling, Weakness, Headaches, Paralysis)	Y / N	
Psychiatric (Depression, Anxiety, Bipolar Disorder)	Y / N	
Endocrine (Excessive Hunger, Thirst, or Sweating, Thyroid Problems)	Y / N	
Hematological/Lymphatic (Anemia, Bruising, Bleeding Problems)	Y / N	
Female (Breast Lump/Pain; Menses: Heavy /Painful, PMS)	Y / N	
Male (Testicular Pain/Lump, Dribbling, Frequent Urination at Night)	Y / N	
Other:	Y / N	

How would you describe the emotional climate of your home?

What potential obstacles do you foresee when adhering to a therapeutic protocol or achieving your goals?

Family History

Please indicate all known, diagnosed medical conditions, illnesses and surgeries of any of the following family members: mother, father, grandmother, grandfather, siblings. Please indicate if it is a current condition or a condition in the past.

Family Member	**Diagnosis**

☐ I do not know my family medical history

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