Alternative Health Empowerment, Inc.
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Adult Naturopathic Intake Form

Personal Information

Date: _____

Name:_____ Age:_____ Birth Date:_____ Sex: M ☐ F ☐

Address:_____ City: _____

State:_____ Postal Code: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Email: _____

Occupation: _____ Employer: _____

Marital Status: ☐Married ☐Single ☐Widowed ☐Divorced ☐Separated ☐Common-law

Number of Children:_____

Family Physician:_____

Phone number:_____ Fax number: _____

In case of emergency contact: _____

Address:_____ Phone number: _____

Relationship: _____

How did you hear about the clinic? _____

Have you seen a Naturopathic Doctor before? ☐Yes ☐No

If yes, for what ailment(s)? _____

Are any other members of your family seeing a Naturopath in this clinic? ☐Yes ☐No

Current History

What health concerns brought you in to the clinic today?

1. _____ 3. _____
2. _____ 4. _____

Has anything changed recently or become worse?

_____

_____

_____

How has this affected your life?

_____

_____

_____

Any religious affiliations or beliefs relevant to your health care and treatment?

_____

_____

_____

What other therapies are you currently using? (Please check)

☐ Chiropractic ☐ Physiotherapy ☐ Massage Therapy ☐ Osteopathy

☐ Craniosacral Therapy ☐ Acupuncture ☐ Bowen Therapy ☐ Other_____

Please list all of your known allergies (medications, food, pollen, etc.): _____

_____

_____

_____

_____

Medication and Supplement History

Please list all supplements, herbs and medications you are currently taking:

Medication/Supplement	Dosage	Since	Reason

History of antibiotic use:

When:_____

For what condition(s):_____

_____

_____

_____

Health History

Please indicate which of the following conditions you have had:

☐Abscesses	☐Depression	☐Heart Disease	☐Mononucleosis	☐Rubella	☐Tonsillitis
☐Alcoholism	☐Diabetes	☐Hepatitis	☐Mumps	☐Scarlet Fever	☐Tuberculosis
☐Allergies	☐Emphysema	☐Genital Herpes	☐Parasites	☐Sexual abuse	☐Typhoid
☐Amnesia	☐Epilepsy	☐Influenza	☐PID*	☐Skin disease	☐Venereal disease
☐Arthritis	☐Gall Stones	☐Kidney disease	☐Peritonitis	☐Strep Throat	☐Warts
☐Asthma	☐Goiter	☐Leukemia	☐Pleurisy	☐Sinusitis	☐Whooping Cough
☐Cancer	☐Gonorrhea	☐Malaria	☐Pneumonia	☐Sunstroke	☐Worms
☐Chicken Pox	☐Gout	☐Measles	☐Prostatitis	☐Stroke	☐Yellow Fever
☐Cold Sores	☐Hay Fever	☐Miscarriage	☐Rheumatic Fever	☐Syphilis	

*Pelvic Inflammatory Disease

Other (Please List)_____

_____

_____

_____

Any conditions which have gotten progressively worse or from which you have not completely recovered?

_____

_____

_____

_____

Do you have any of the following:

Amalgam (silver) fillings	☐Yes	☐No	Root canal	☐Yes	☐No
Periodontal disease	☐Yes	☐No	Dental implants	☐Yes	☐No
Orthodontics	☐Yes	☐No			

Please indicate if you've had any hospitalizations, surgeries or serious injuries:

Operation	When	Complications?

Injuries:

Injury	When	Long-term Effects?

WOMEN ONLY

Are you currently on the Birth Control Pill? ☐Yes ☐No

Brand (Alesse, Ortho-Tricyclin etc.): _____

How long have you been on the Pill? _____

Age of first period: _____ Last Menstrual Period: _____

Last Pap (date): _____

Last Breast Exam (date) _____ Bone Density Testing _____

Were these tests normal? ☐Yes ☐No

Age at onset of menopause (if applicable): _____

Number of pregnancies? _____ Number of live births? _____

MEN ONLY

Do you have difficulty with maintaining or achieving an erection? ☐Yes ☐No

Last prostate exam: _____ PSA (blood test done) ☐Yes ☐No

Diet and Lifestyle

Have you lost any weight lately? ☐Yes ☐No If yes, how many pounds? _____

How much of the following substances do you use on a daily basis?

Tobacco: _____ Alcohol: _____ Coffee: _____ Soda Pop: _____

Recreational Drugs: _____

Are there any foods or food groups that you avoid? ☐Yes ☐No

If yes, which ones and why? _____

_____

_____

_____

Food cravings: _____

Do you consume dairy products? ☐Yes ☐No

Do you choose organic food? ☐Yes ☐No What types? _____

_____

_____

Do you consume freshwater fish? ☐Yes ☐No What types? _____

Please indicate if you use any of the following:

☐Alcohol	☐Carbonated beverages	☐Tobacco	☐Coffee	☐Tea	☐Laxatives
☐Candy	☐Fast food	☐Fried foods	☐Antacids	☐Margarine	☐Salt
☐Distilled water	☐Lunch meats	☐Plastic wrap	☐Microwave	☐Non-sugar sweetener	

How often do you engage in physical activity?

Daily_____ 2-3 times/week_____ once a week_____ less than once a week_____

What type of activities? _____

_____

On average, how many hours of sleep do you get per night? _____

Do you have interrupted sleep? ☐Yes ☐No

Do you wake rested? ☐Yes ☐No

Any dietary restrictions? (Religious or otherwise) _____

_____

_____

How many glasses/ounces of water per day do you drink? _____

What kind of water do you drink? ☐Distilled ☐Tap ☐Filtered tap water ☐Reverse Osmosis ☐Plastic bottled water

☐Glass bottled water ☐Ionized alkaline water

Digestion and Elimination

Digestion (check or fill in the answers)

Do you have any problems with gas, bloating or fullness after eating? ☐Yes ☐No

How often? ☐Often ☐Sometimes ☐Never / How severe is it? ☐Mild ☐Moderate ☐Severe

Any heartburn? ☐Yes ☐No How often? _____

Do you have gas in the upper or lower part of the abdomen or is it both areas? _____

How long have you had this problem? _____

How often do you have bowel movements? _____

Do you ever have any blood, mucus, undigested food or black stools (movements)? ☐Yes ☐No

Do you have rectal itching? ☐Yes ☐No. Do your stools tend to be formed or loose? _____

How often do you have diarrhea? _____

Do you ever have alternating constipation and diarrhea? ☐Yes ☐No

How often do you have thin, long and narrow stools? ☐Often ☐Sometimes ☐Never

Do you ever have small and hard stools? ☐Often ☐Sometimes ☐Never

Do your stools have a strong disagreeable odor? ☐Often ☐Sometimes ☐Never

Have you ever fasted? ☐Yes ☐No Juice or water? _____. How long did you fast? _____

How did you feel while you were fasting? _____

Have you traveled outside of the United States in the last 5 years? ☐Yes ☐No

Camping in the past 5 years? ☐Yes ☐No

Kidneys and Bladder

Have you had recurrent bladder infections? ☐Yes ☐No

How were they treated? _____

How many bladder infections have you had in the last 3 years? _____

Do you have any burning sensation during or after urination? ☐Yes ☐No In the past ____ or present ____

Is your urine; ☐dark yellow ☐bright yellow ☐cloudy ☐pale or ☐clear?

Does your urine have a strong odor to it? ☐Yes ☐No

Do you have difficulty starting or stopping when urinating? ☐Yes ☐No

Do you have difficulty perspiring? ☐Yes ☐No

Do you perspire when you exercise? ☐Slightly ☐Moderately ☐Heavily

Do you perspire at other times, other than when exercising? ☐Yes ☐No

If yes, when: _____

Does your perspiration have a strong odor? ☐Yes ☐No

Does your temperature tend to run low ____ high ____ or average ____ compared to others?

Occupational and Household

How long have you lived at your present address? _____

Where have you lived previously? _____

Please describe location, if old or new building, i.e., new construction, older construction, damp or moldy, etc.

_____

Do you have specialized air filtration at home? ☐Yes ☐No

Do you live in a city? ☐Yes ☐No

Do you work in an office building? ☐Yes ☐No. Do the windows open? ☐Yes ☐No

Do you work in the presence of toxic fumes or chemicals? ☐Yes ☐No

Do any of your hobbies involve toxic materials? ☐Yes ☐No

Are you currently exposed to second hand smoke? ☐Yes ☐No

Do you have anything else you would like to comment on? _____

_____

_____

_____

Family Health History

Please indicate each relevant condition for blood relatives only.

☐Abscesses	☐Depression	☐Heart Disease	☐Mononucleosis	☐Rubella	☐Tonsillitis
☐Alcoholism	☐Diabetes	☐Hepatitis	☐Mumps	☐Scarlet Fever	☐Tuberculosis
☐Allergies	☐Emphysema	☐Genital Herpes	☐Parasites	☐Sexual abuse	☐Typhoid
☐Amnesia	☐Epilepsy	☐Influenza	☐PID*	☐Skin disease	☐Venereal disease
☐Arthritis	☐Gall Stones	☐Kidney disease	☐Peritonitis	☐Strep Throat	☐Warts
☐Asthma	☐Goiter	☐Leukemia	☐Pleurisy	☐Sinusitis	☐Whooping Cough
☐Cancer	☐Gonorrhea	☐Malaria	☐Pneumonia	☐Sunstroke	☐Worms
☐Chicken Pox	☐Gout	☐Measles	☐Prostatitis	☐Stroke	☐Yellow Fever
☐Cold Sores	☐Hay Fever	☐Miscarriage	☐Rheumatic Fever	☐Syphilis	☐Multiple Sclerosis
☐PMS	☐HIV	☐Frequents colds	☐Eczema	☐Sinusitis	☐Hypertension
☐Anemia	☐Obesity	☐Ulcers	☐Eye problems	☐Adenoiditis	☐Thyroid problems

Any other condition(s) not listed: _____

_____

Indicate which of the above conditions have affected your relatives:

Family Member	Age (if alive)	Age at death	Condition