Patient Intake Forms

Date: ____________________

Name: ______________________________ Age: _________ Date of Birth (yyyy/mm/dd): ____________________

Address: ______________________________ City: ____________________ Postal Code: ____________________

Telephone (Home): ____________________ (Work): ____________________ (Mobile): ____________________

Email: ______________________________ Marital Status: ______________________________

Occupation: ______________________________ Employer: ______________________________

Name of Medical Doctor: ______________________________ Telephone: ____________________

How were you referred to this clinic? ______________________________

Have you been treated by a Naturopathic Doctor before? Yes: _________ No: _________

Please list your major complaints in order of importance

COMPLAINTS	FOR HOW LONG?

What medications are you currently taking?

MEDICATIONS / SUPPLEMENTS	FOR HOW LONG?

What other treatments are you currently following, if any? (i.e. physiotherapy, chiropractic, massage)

____

____

Please list allergies, if any? (i.e. food, drugs, environmental)

Immunizations and reactions, if any?

Operations or significant injuries, if any?

Family Medical History

MOTHER	
FATHER	
SIBLINGS	
GRANDPARENTS	
CHILDREN	

Lifestyle

Please check if you use any of the following:

__ ALCHOHOL	__ CANDY/REFINED SUGARS	__ COFFEE	__ BOTTLED SPRING WATER
__ SMOKING	__ TUPPERWARE FOR FOOD STORAGE	__ TEA	__ FILTERED WATER
__ FAST FOOD	__ ALUMINUM PANS, TEFLON	__ FRIED FOOD	__ RECREATIONAL DRUGS
__ COLD CUTS	__ CARBONATED BEVERAGES	__ TAP WATER	__ EATING OUT TIMES/WEEK

EXCERCISE? Y / N	WHAT TYPE? ____	HOW OFTEN? ____
HOW MANY HOURS OF SLEEP A NIGHT? ____	DO YOU SLEEP WELL? Y / N	AWAKEN RESTED? Y / N
EXCESSIVE STRESS IN LIFE? Y / N	EAT 3 MEALS A DAY? Y / N	ENJOY WORK? Y / N
WIFI/CELL PHONES ON DURING SLEEP? Y / N	MOLD IN HOME? Y / N	RADON TESTED HOME? Y / N
USE NATURAL CLEANING PRODUCT(S)? Y / N	ASBESTOS IN HOME? Y / N	
LIVING CLOSE TO HYDRO TOWER? Y / N	PESTICIDE USE ON PROPERTY? Y / N	

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Please check any condition you have **now** or have had in the **past**:

A. General Symptoms

___ Wt.______ Ht.______
___ Fatigue & Weakness
___ Fever
___ Chills
___ Sweats
___ Loss of Weight
___ Weight Gain
___ Frequent Cold & Flu
___ Anemia
___ Blood Transfusions
___ Easy Bruising & Bleeding
___ Lymph Node Swelling
___ Food Allergies
___ Drug Allergies
___ Depression
___ Anxiety
___ Alcoholism
___ Cancer

B. Skin

___ Rashes
___ Eczema
___ Psoriasis
___ Acne
___ Itchy
___ Dryness
___ Oily
___ Skin Colour Changes
___ Hair Changes
___ Skin Growths
___ Mole Changes

C. Head

___ Headache
___ Dizziness
___ Head Injury
___ Migraines

D. Ears

___ Impaired Hearing
___ Ringing
___ Loss of Balance
___ Vertigo
___ Ear Pain
___ Ear Infections
___ Discharge from Ear

E. Eyes

___ Impaired Vision
___ Glaucoma
___ Cataracts
___ Double Vision
___ Bothered by Sun
___ Eye Pain
___ Eye Itching
___ Eye Redness
___ Tearing
___ Eye Dryness
___ Blurring
___ Eye Discharge

F. Nose & Sinuses

___ Nose Bleeds
___ Allergies
___ Sinus Problems
___ Congestion
___ Discharge from Nose
___ Nasal Polyps

G. Mouth & Throat

___ Frequent Sore Throat
___ Strep Throat
___ Loss of Taste
___ Cold Sores
___ Sore Tongue & Mouth
___ Cankers
___ Bleeding Gums
___ Dental Cavities & Fillings
___ Implants
___ Root Canals
___ Tonsils Removed
___ Mono

H. Neck

___ Lumps
___ Pain or Stiffness
___ Enlarged Lymph Nodes
___ Enlarged Thyroid

I. Respiratory

___ Cough
___ Wheezing
___ Asthma
___ Bronchitis
___ Throat Phlegm
___ Breathing Difficulties

J. Cardiovascular

___ Heart Disease
___ Chest Pain & Angina
___ Heart Attack
___ Stroke
___ Palpitations & Fluttering
___ High Blood Pressure
___ High Cholesterol
___ Purplish/Bluish Skin
___ Heart Murmur
___ Ankle Swelling
___ Gout

K. Gastrointestinal

___ Trouble Swallowing
___ Increase/Decrease Thirst
___ Increase/Decrease Appetite
___ Nausea
___ Vomiting
___ Heartburn & Indigestion
___ Belching & Passing Gas
___ Number of Bowel Movements per Day
___ Constipation
___ Diarrhea
___ Blood in Stool
___ Hemorrhoids/Fissures
___ Abdominal Pain
___ Hernias
___ Ulcer
___ Liver Disease
___ Diverticulosis
___ Polyps
___ Appendix Removal
___ Gall Stones
___ Gallbladder Removal
___ Colonoscopy Ever?
___ Colonoscopy Normal?

L. Urinary

___ Pain Before &/or During Urination
___ Increased Frequency
___ Urgency
___ Hesitancy
___ Inability to Hold Urine
___ Blood in Urine
___ Frequent Bladder Infections
___ Kidney Infections
___ Kidney Disease
___ Kidney Stones

M. Musculoskeletal

___ Joint Pain & Stiffness
___ Joint Swelling
___ Arthritis
___ Back Pain
___ Broken Bones Ever?

Please check any condition you have **now** or have had in the **past**:

- ___ Muscle Spasms & Cramps
- ___ Muscle Weakness
- ___ Osteoporosis or Osteopenia
- ___ Bone Density Test Ever?
- ___ Bone Density Normal?

N. Arms, Legs, Hands & Feet

- ___ Deep Leg Pain
- ___ Cold Hands & Feet
- ___ Varicose Veins
- ___ Numbness
- ___ Tingling
- ___ Coldness
- ___ Swelling
- ___ Ulcers (Feet)

O. Neurologic

- ___ Fainting
- ___ Seizures/Convulsions
- ___ Epilepsy
- ___ Memory Loss
- ___ Speech Problems
- ___ Involuntary Movement
- ___ Paralysis

P. Endocrine

- ___ Heat Intolerance
- ___ Cold Intolerance
- ___ Thyroid Problems
- ___ Diabetes
- ___ Hypoglycemia
- ___ Hormone Medication

Q. Infectious Diseases

- ___ Chicken Pox
- ___ Shingles
- ___ Measles
- ___ Rubella
- ___ Hepatitis A
- ___ Hepatitis B
- ___ Hepatitis C
- ___ Herpes
- ___ HPV
- ___ Warts
- ___ Parasite
- ___ Mycoplasma
- ___ HIV

R. Male

- ___ Rectal Itching
- ___ Testicular Mass
- ___ Testicular Pain
- ___ Low Libido
- ___ Sexually Active
- ___ Sexual Difficulties
- ___ Prostate Problems
- ___ Discharge
- ___ Sores
- ___ Hernia

S. Women

- ___ Duration of Period (days)
- ___ Length of Cycle (days)
- ___ Irregular Cycle
- ___ Painful Periods
- ___ Bleeding Between Periods
- ___ Heavy Periods
- ___ Light Periods
- ___ P.M.S.
- ___ Low Libido
- ___ Sexually Active
- ___ Sexual Difficulties
- ___ Pain During Intercourse
- ___ Birth Control
- ___ Number of Pregnancies
- ___ Breastfeeding (past or present)
- ___ Miscarriage
- ___ Abortion
- ___ Difficulty Conceiving
- ___ Breast Pain /Tenderness
- ___ Breast Lumps
- ___ Nipple Discharge
- ___ Uterine Fibroids
- ___ Uterine Polyps
- ___ Ovarian Cysts
- ___ Vaginal Discharge
- ___ Vaginal Itching
- ___ Vaginal Yeast Infections
- ___ Genital Herpes
- ___ Menopausal Symptoms
- ___ Last Breast Exam (Date)
- ___ Normal Breast Exam?
- ___ Last Pap Exam (Date)
- ___ Normal Pap Exam?