NATUROPATHIC INTAKE FORM

Today's Date: _____

An accurate health history is important to ensure safe and effective treatment. However, if there are questions that you would rather not answer, or prefer to discuss in person, feel free to do so. If there is anything missing from the form you think I should know, please write on the back.

Name: _____ Email address: _____
Address: _____ Postal code: _____
Phone: (home) _____ (work) _____
Date of birth: _____ Age: _____ Occupation: _____
Emergency contact: _____ Relation: _____ Phone #: _____
Referred by? _____ Family Medical Doctor: _____

What are your health goals (*any specific areas or other conditions you would like to address*)?
(Use extra sheet or back if more space is needed)
Please rate your commitment to healing/solving the condition out of 10 (10 being 100% committed) ___/10
1. _____
2. _____
3. _____
4. _____
5. _____
Can you think of any obstacles to your recovery/healing? _____

Are you currently seeing any other health care practitioners?
Chiropractor _____ Massage Therapist _____ Psychotherapist _____ Other? _____
Names: _____

List all food supplements you are presently taking. Indicate the total dosage taken in one day. (i.e. if you take 2 tablets of Vitamin C 500mg/day = Total daily is 1000mg). Indicate brand if possible.

_____
_____
_____
_____
_____

Medications:

List all prescribed medications *currently* taken: (*Indicate drug, dosage, frequency and how long you've been taking it)*

_____
_____
_____

List all prescribed medications you've taken in the *past* for any period longer than three months:

_____
_____

How many courses of antibiotics have you had in the past 10 years? _____

List any medications you have had a bad reaction to in the past, when it was, and what the reaction was:

_____
_____

List any over-the-counter medications you take (*i.e. Aspirin, Tums, etc*.) Indicate whether you take it rarely, occasionally, frequently or daily.

_____

Do you use recreational drugs (i.e. marijuana)? Yes _____ No _____
If yes, indicate type and frequency of usage:

_____

Health History:

Check any of the following conditions you have had, please star those you still experience:

Measles _____	**Gallstones** _____	**Bowel Disease** _____	**Mumps** _____
High blood pressure _____	**Hives** _____	**Scarlet Fever** _____	**Pleurisy** _____
Whooping cough _____	**Malaria** _____	**Arthritis** _____	**Pneumonia** _____
Croup _____	**Parasites** _____	**Rheumatism** _____	**Tuberculosis** _____
Asthma _____	**Diarrhea** _____	**Gout** _____	**Genital herpes** _____
Eczema _____	**Constipation** _____	**Kidney stones** _____	**Gonorrhea** _____
Allergies _____	**IBS** _____	**Hypoglycemia** _____	**Chlamydia** _____
Hay fever _____	**Candida** _____	**Depression** _____	**Shigella** _____
Sinusitis (chronic) _____	**Mononucleosis** _____	**Anxiety** _____	**Influenza** _____
Swollen glands _____	**Cancer** _____	**Ear infection** _____	**Chicken pox** _____
Diphtheria _____	**Migraines** _____	**Endometriosis** _____	**Thyroid disorder** _____
Bronchitis _____	**Eating disorder** _____	**Liver problems** _____	

Other: _____

Were any of the above severe? If so, please give the age, severity and duration:

_____

_____

Describe your general state of health as a child: _____

_____

Describe your general state of health as a teenager: _____

_____

<u>Surgeries</u>: Please indicate the type of surgery and when it was performed:

_____

_____

<u>Accidents</u>: Please indicate severity, injuries sustained, when it occurred, and any treatment required:

_____

_____

Family History:

Please indicate the age of all relatives living, and indicate the age at which any family member became deceased (L= Living, D= Deceased).

Mother	**L** _____	**D** _____		**Father**	**L** _____	**D** _____	
Sisters	**L** _____	**D** _____		**Brothers**	**L** _____	**D** _____	
	L _____	**D** _____			**L** _____	**D** _____	

Indicate if there have been any of the following diseases in your grandparents or parents, brothers and sisters. Indicate the number of relatives who have/had the disease:

Diabetes _____	**Cancer** _____	**Heart disease** _____
Mental illness _____	**Alzheimer's** _____	**Stomach disorders** _____
Tuberculosis _____	**Arthritis** _____	**Thyroid problems** _____
Rheumatism _____	**Allergies** _____	**Hypertension (high blood pressure)** _____
Kidney disease _____	**Stroke** _____	

If not already mentioned, is there a family history of your chief health concern? _____

Do you have any of the following? ***(circle)***

Amalgam (silver) fillings	**YES NO**	**Dental implants?**	**YES NO**
Root canal	**YES NO**	**Orthodontics?**	**YES NO**
Periodontal disease	**YES NO**		

Male:

Do you have any difficulty voiding (urinating) completely? _____
How often do you get up to go to the bathroom at night? _____
Have you been diagnosed with a prostate problem? _____
Do you have difficulty getting and maintaining erections? _____
Do you have difficulty with premature ejaculation while having intercourse? _____
Do you have any other problems concerning sexual health? _____
Do you have any children? _____ **Names and ages:** _____

Lifestyle:

How many 8oz glasses of water do you drink per day? _____ **Type of water? Filtered Tap Well**

How often do use or consume: (0= never 1= rarely, 2= weekly, 3= daily)
Artificial sweeteners _____ **Sugar/sweets** _____ **Carbonated beverages** _____
Alcohol _____ **Luncheon meat** _____ **Refined/processed foods** _____
Dairy products _____ **Recreational drugs** _____
Coffee _____ **Tea** _____ **Tobacco** _____ **→ if 1-3 for how long?** _____

Any dietary restrictions? (Religious or otherwise, e.g. vegetarian)

_____

How many hours of sleep do you get on average? _____ **Do you wake rested? YES NO**
Do you have any trouble: Falling asleep? YES NO Staying asleep? YES NO
How many hours do you work each day? _____

What do you do for exercise? (Indicate type, frequency, and length of time on each occasion).

_____
_____

Have you had any dramatic changes in your weight in the last 10 years? _____

What do you do for recreation? _____
_____

What level of personal stress are you experiencing right now from 0-10? (10 being the highest) _____

Which are the main stressors? **Financial** _____ **Job related** _____ **Interpersonal** _____ **Marriage** _____
Unfulfilled expectations _____ **Health** _____ **Family members** _____ **Spiritual** _____
Other: _____

Do you have a community/social network/spiritual or religious discipline that you can rely on for strength or support? _____

Is there anything you think I should know that hasn't been covered in this intake form? _____
_____

Part II

Scoring: Circle number (*Circle or underline specifics where applicable)*

0= NO, symptom does not occur **1= Yes, minor/mild symptom, rarely occurs (monthly)**
2= Moderate symptom, occurs occasionally (weekly) **3= Severe, occurs frequently (daily)**

Digestion

0 1 2 3 Belching, bloating, fullness after eating – within 30 minutes 60 minutes 1-2 hours
0 1 2 3 Heart burn or reflux (GERD)
0 1 2 3 Fingernails chip, peel or break easily, or have ridges
0 1 2 3 Stomach pains or cramps – Upper abdomen Lower Whole abdomen
0 1 2 3 Any blood, mucus, undigested food or black stools (bowel movements)?
0 1 2 3 Rectal itching
0 1 2 3 Stools are small and hard
0 1 2 3 Alternating constipation and diarrhea
0 1 2 3 Stools are thin, long and narrow (finger diameter or less)
0 1 2 3 Stools or gas have a strong disagreeable odour

How often do you have a bowel movement? _____ Stools tend to be – Formed Loose
Have you traveled outside Canada in the last 5 years? YES NO Camping in last 5 years? YES NO
Do you have any pets? YES NO – Cat Dog Other

Nutrient questionnaire

A

0 1 2 3 Low fat diet (0= never, 1= years ago, 2= within past year, 3= currently)
0 1 2 3 Pain or swelling in joints or tendons
0 1 2 3 Morning stiffness
0 1 2 3 Tension headaches at base of skull
0 1 2 3 Headaches when in hot sun
0 1 2 3 Muscles easily fatigued
0 1 2 3 Dry flaky skin or dandruff
0 1 2 3 Small bumps on back of arms
0 1 2 3 Gallbladder removed or gallbladder problems – YES NO
0 1 2 3 Difficulty digesting (discomfort with) fats – YES NO

B

0 1 2 3 Body jerks on falling asleep
0 1 2 3 Calf, foot or toe cramps at rest
0 1 2 3 Cold sores or herpes lesions
0 1 2 3 Frequent hives or skin rashes
0 1 2 3 Crave chocolate
0 1 2 3 Feet have a strong odour
0 1 2 3 White spots on fingernails
0 1 2 3 Cuts heal slowly or scar easily
0 1 2 3 Decreased sense of smell or taste

C

0 1 2 3 Vulnerable to insect bites
0 1 2 3 Heaviness in arms or legs, and/or loss of muscle tone
0 1 2 3 Numbness, tingling, or itching in hands and feet
0 1 2 3 Worrier, anxious, apprehensive
0 1 2 3 Can hear heart beat on pillow at night
0 1 2 3 Night sweats (adrenal, liver, vitamin)
0 1 2 3 Bright light irritates eyes, tend to need sunglasses
0 1 2 3 Cracks at corner of mouth
0 1 2 3 Nose bleeds or tend to bruise easily (circle which one)
0 1 2 3 Bleeding gums with brushing teeth