

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: _____

Surgeries: Please indicate the type of surgery and when it was performed:

Accidents: 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