

Please have this form completed for your initial visit.  
Indicate N/A for items that you feel are non-applicable.

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of Birth: MM/DD/YYYY Sex: M / F

Address/Postal Code \_\_\_\_\_

Phone (H) \_\_\_\_\_ Phone (W) \_\_\_\_\_ Phone (cell) \_\_\_\_\_ Fax \_\_\_\_\_

May I leave you messages in regards to your appointments? Y / N

Email \_\_\_\_\_

Occupation \_\_\_\_\_ Place of Work \_\_\_\_\_

Emergency Contact Name \_\_\_\_\_ Emergency Contact Number \_\_\_\_\_ Relation \_\_\_\_\_

Marital Status/Living Arrangement \_\_\_\_\_

Family Physician \_\_\_\_\_ Phone \_\_\_\_\_ Fax \_\_\_\_\_

Other Health Care Practitioners \_\_\_\_\_ Phone \_\_\_\_\_

Have you seen a Naturopathic Doctor before? Y / N

How did you hear about this clinic? \_\_\_\_\_

Health Concerns (Please list in order of importance)

1. _____	3. _____	5. _____
2. _____	4. _____	6. _____

Medical History

Date of last physical exam: \_\_\_\_\_ Height: \_\_\_\_\_ Weight: \_\_\_\_\_

Current medications + dosages (including over-the-counter): \_\_\_\_\_

Past medications: \_\_\_\_\_

How many times have you been treated with antibiotics? \_\_\_\_\_

Current supplements or herbal products + dosages: \_\_\_\_\_

List any known allergies: \_\_\_\_\_

From what you recall, please circle the childhood infections that you have experienced:  
Measles / German Measles / Chicken Pox / Mumps / Whooping Cough / Rheumatic Fever / Diphtheria / Scarlet Fever / Polio

Other: \_\_\_\_\_

Please list any major lab testing or medical procedures performed in the last 3 years? \_\_\_\_\_

Traumas/Surgeries/Accidents/Diseases:

Please list all major accidents, hospitalizations, surgeries, diseases and traumatic events, and your age at the time:  
Please continue on the back of this page if you require additional space.

1. \_\_\_\_\_ Age: \_\_\_\_\_

2. \_\_\_\_\_ Age: \_\_\_\_\_

3. \_\_\_\_\_ Age: \_\_\_\_\_

4. \_\_\_\_\_ Age: \_\_\_\_\_

5. \_\_\_\_\_ Age: \_\_\_\_\_

Family Medical History: Please check the appropriate box if you or a family member have had any of the following conditions:

	You	Mother	Father	Sister/Brother	Grandparents
Alcoholism					
Anemia					
Arthritis (Osteo or Rheumatoid)					
Asthma/Allergies					
Autoimmune Disease (Lupus, etc)					
Cancer (Give type)					
Chronic Fatigue/Fibromyalgia					
Depression/Mood swings					
Diabetes					
Eczema/Psoriasis					
Heart disease/Angina/ High blood pressure					
Kidney Disease					
Osteoporosis					
Schizophrenia/Delusions/Alzheimer's					
Thyroid abnormalities					
Tuberculosis/Lung Disease					
Other:					

Lifestyle

Do you smoke cigarettes? Y / N If yes, how many cigarettes per day? \_\_\_\_\_

Do you use recreational drugs? Y / N If yes, please specify: \_\_\_\_\_

Do you drink alcohol? Y / N If yes, how much alcohol per week: \_\_\_\_\_

Have you ever been treated for an addiction to drugs, alcohol, or prescription medications? Y / N

How many times do you exercise per week? \_\_\_\_\_ What form of exercise? \_\_\_\_\_

How many hours do you sleep per night? \_\_\_\_\_ Do you have difficulty falling asleep? Y / N

How often do you wake through the night? \_\_\_\_\_ Do you awake in the morning feeling rested? Y / N

On a scale of 1-10 (10 is highest) rate your energy levels in the morning \_\_\_\_\_ afternoon \_\_\_\_\_ evening \_\_\_\_\_

Please list the top three sources of stress in your life: 1) \_\_\_\_\_ 2) \_\_\_\_\_ 3) \_\_\_\_\_

Do you experience depression? Y / N Do you experience mood swings? Y / N

Have you experienced mental, emotional, or sexual abuse? Y / N

Have you received psychiatric/psychological counseling? Y / N

What do you do in your leisure time? \_\_\_\_\_

What do you do to relax? \_\_\_\_\_

Environment

List any household pets: \_\_\_\_\_

Seasonal allergies? Y / N If yes, please specify: \_\_\_\_\_

Are you affected by scented products/perfumes? Y / N

Please circle all that apply to your living environment: apartment / basement / house / near or on a farm / near a golf course

Approximately what year was your home or dwelling built? \_\_\_\_\_ How is it heated? \_\_\_\_\_

Are chemicals used on your lawn/garden? Y / N What is your source of drinking water? \_\_\_\_\_

Are you exposed to any chemicals/hazardous materials on a regular basis? \_\_\_\_\_

How would you describe the emotional climate in your home? \_\_\_\_\_

\_\_\_\_\_

List factors in your home/work environment that might adversely affect your health/well-being?

\_\_\_\_\_

\_\_\_\_\_

Nutritional Habits

Briefly describe a typical day's diet:

Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_  
Dinner: \_\_\_\_\_ Snacks: \_\_\_\_\_  
Beverages: \_\_\_\_\_ How much water do you drink each day? \_\_\_\_\_  
Please list your favorite foods: \_\_\_\_\_  
Do you have food cravings? Y / N If so, list foods: \_\_\_\_\_  
Do you drink coffee? Y / N If so, how many cups per day? \_\_\_\_\_  
List any known food allergies or intolerances: \_\_\_\_\_  
List dietary restrictions (religious/vegetarian/vegan, etc.)? \_\_\_\_\_  
How many bowel movements do you have a day? \_\_\_\_\_ Do you experience diarrhea / constipation? (circle)

Please use the space below to indicate any additional information:

Thank you for taking the time to complete this intake form.