Rooted… 93 Bell Farm Rd. unit 103 705.792.6717

Naturopathic Medicine
INTAKE FORM

PERSONAL INFORMATION

Name: ____ Date: ________________________

Date of Birth: ______________________ Age: ______ Sex/gender: ___________________

Home Address: ____

City: ______________________________ Postal Code: ______________________________

Home Telephone: _________________________Other Telephone: __________________________

What number may we leave messages at? ____

Email address: ____
(would you like to be included in our e-mail list? Yes No)

Emergency contact: ________________________________ Phone: ___________________________

Has any other family member already been a client of this clinic? ______________________________

How did you find out about us? (please check all that apply)

☐ Yellow Pages ☐ Friend Whom should we thank?____________________________
☐ Webpage ☐ Professional referral Whom should we thank? __________________
☐ OAND ☐ Social Media – Facebook, Twitter, etc ☐ Other

Health Care Team:
Family Physician: _______________________________ Phone: ____________________________

Other Health Care Providers: _______________________ Phone: ____________________________

Date of last physical exam:_________________________ Blood tests done? Y N

Do you get regular screening tests done by a doctor? (Pap, blood, etc.) Y N

What *three* expectations do you have from *this visit* to our clinic?
1. ____
2. ____
3. ____

What *long term* expectations do you have from working with our clinic?
1. ____
____
2. ____
____

CHIEF HEALTH CONCERNS: What are your health concerns in order of importance

____

____

____

____

____

Have you had any serious conditions, illnesses, injuries, and/or diseases in the past? Please list approximate dates and reasons:

____

____

ENVIRONMENT AND LIFESTYLE

Occupation: ____Hours per week: ___________________

Do you exercise regularly? Y N
What types: ______________________________ How often? ______________________________

Who sincerely and consistently supports you in a positive and beneficial way? ____________________
____

Do you: ☐ Live alone ☐ Live with partner ☐ Live with friends ☐ Children ☐ Other______________

How would you describe the emotional climate of your home?________________________________

What causes you the most stress/worry in life? ____
____

How do you manage your stress? (include positive and negative ways)__________________________
____

What are you hobbies, what do you love to do? ____

____

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions.
Indicate below any **accidents, broken bones, falls, illnesses, hospitalization, surgeries, CT's, MRI's, X-rays,** and note any emotional circumstances such as **deaths, loss of jobs, marriage, divorces, abuse, addictions, etc.**

Age	Event (stress, accident, imaging, illness, etc)
1-5	
5-10	
10-15	
15-20	
20-25	
25-30	
30-35	
35-40	
40-45	
45-50	
50-55	
55-60	
60-65	
65-70	
70-80	
80-90	

HEALTH HISTORY:
Do you have any allergies (foods, environmental, medications)? Please List

Allergy	What problems do they give you? Diarrhea, stuffy nose, anaphylaxis, etc.	How often are you exposed? Daily, weekly, monthly, etc.	When did you first become aware of the allergy/problem?

Please list all current **prescription medications**:

Name of medication	Dose	Frequency	Duration	Side effects (if any)

Please list all **<u>vitamins, herbs, homeopathics, and non-prescription medications</u>** that you take on a regular basis:

Name and Brand	Dose	Frequency	Duration	Side effects (if any)

Approximately how many times <u>per year</u> have you been treated with antibiotics?
As a child? ________As an Adult?________________

How often do you use the following:

	Per day	Per week	Per Month
Caffeine			
Cigarettes			
Diet pills			
Pain Relievers			
Sleeping pills/aids			
Antacids			
Laxatives			
Alcohol			
Recreational Drugs			
Fast Food			

Do you follow any special dietary plans? (Religious, vegetarian, vegan, etc.)
____
____

List any foods that you crave or make you feel better:

Food/drink the you crave	Approximately how often do you have them? (daily, weekly, etc.)

GENERAL HISTORY:

(For the following list of symptoms: √ for currently experiencing and P for those you've had in the past)

SKIN:
❑ Rashes
❑ Eczema
❑ Psoriasis
❑ Vitilago
❑ Dryness
❑ Hives
❑ Boils
❑ Acne
❑ Warts
❑ Recent moles
❑ Skin cancer
❑ Change in skin texture

HEAD:
❑ Head injury
❑ Headaches/Migraines
❑ Vertigo/Dizziness
❑ Hair loss
❑ Dandruff
❑ Change in hair texture

EYES:
❑ Redness
❑ Excessive tearing
❑ Double/Blurred vision
❑ Spots/floaters
❑ Flashing lights
❑ Glaucoma
❑ Cataracts
❑ Discharge/infection
❑ Eye strain
❑ Eye pain

EARS:
❑ Infection
❑ Ringing
❑ Hearing loss

NOSE & SINUSES:
❑ Frequent colds
❑ Nasal stuffiness
❑ Loss of smell
❑ Nose bleeds
❑ Nasal polyps
❑ Sinus infections
❑ Chronic runny nose
❑ Peculiar smells

MOUTH & THROAT:
❑ Bleeding gums
❑ Sores in mouth
❑ Periodontal disease
❑ Thrush
❑ Sore throat
❑ Enlarged lymph nodes
❑ Torticollis/stiff neck
❑ Peculiar tastes
❑ Production of mucus

RESPIRATORY:
❑ Cough
❑ Wheezing
❑ Asthma
❑ Bronchitis
❑ Pneumonia
❑ Emphysema
❑ Coughing blood
❑ Tuberculosis
❑ Central chest pain

CARDIOVASCULAR:
❑ Rapid heart beat
❑ High blood pressure
❑ Low blood pressure
❑ Chest pain
❑ Palpitations
❑ Heart murmurs
❑ Rheumatic fever
❑ Difficult breathing
❑ Leg cramps
❑ Thrombophlebitis
❑ Edema/swollen ankle
❑ Cold hands/feet

INTESTINAL
❑ Trouble swallowing
❑ Nausea
❑ Vomiting
❑ Heartburn/regurgitation
❑ Indigestion
❑ Bad breath
❑ Bloating
❑ Abdominal pain
❑ Excessive gas
❑ Ulcer
❑ Hypoglycemia
❑ Diabetes
❑ Jaundice/hepatitis
❑ Colitis or Crohn's
❑ Constipation
❑ Blood in stool
❑ Diarrhea
❑ Hemorrhoids
❑ Eating disorder

GENITOURINARY:
❑ Urgency
❑ Dribbling/leaking
❑ Frequency
❑ Incontinence
❑ Burning pain
❑ Urinary tract infections
❑ Kidney infections
❑ Kidney stones
❑ STDs (HPV, etc.)

GENERALS:
❑ Weight loss
❑ Weight gain
❑ Fatigue
❑ Night sweats
❑ Profuse perspiration
❑ Weakness
❑ Insomnia/poor sleep

FEMALE:
❑ PMS
❑ Menopause
❑ Low libido
❑ Yeast infections
❑ Vaginal dryness
❑ Painful periods
❑ Irregular Periods
❑ Heavy periods
❑ Excessive discharge
❑ Miscarriage(s)
❑ Pregnancy(s)
❑ Abortion(s)
❑ Birth control use
❑ Abnormal PAP results
❑ Endometriosis
❑ Uterine Fibroids
❑ Fibrocystic breasts

MALE:
❑ Enlarged prostate
❑ Prostatitis/infection
❑ Discharge
❑ Low libido
❑ Erectile dysfunction

HAEMATOLOGICAL
❑ Anemia
❑ Easy bleeding
❑ Easy Bruising
❑ Varicose/spider veins
❑ Past transfusions
❑ Hep. A, B, or C
❑ HIV

MUSULOSKELETAL
❑ Muscle pains
❑ Joint pains
❑ Osteo-arthritis
❑ Back pain
❑ Muscle spasms/cramps
❑ Joint swelling
❑ Gout

NEUROLOGICAL:
❑ Fainting/Black-outs
❑ Numbness
❑ Tremors
❑ Pins & needles
❑ Loss of balance
❑ Paralysis
❑ Speech problems
❑ Memory loss
❑ Loss of sleep
❑ Nervousness/tension
❑ Irritability
❑ Depression

WEIGHT:

____

HEIGHT:

____

FAMILY HEALTH HISTORY:

Please indicate if a close relative (parent, grandparent, or sibling) has had any of the following)

	Mother	Father	Sibling	Grandparent	Aunt/uncle
Allergies					
Arthritis					
Asthma					
Autoimmune Disease					
Cancer					
Diabetes					
Digestive Disorders					
Heart Disease					
High Blood Pressure					
Mental Illness					
Multiple Sclerosis					
Stroke					
Tuberculosis					
Macular degeneration					
Glaucoma					
Thyroid conditions					
other					

Is there anything else that you would like to add but weren't sure where it fit?

____