Alison Danby
NATUROPATHIC DOCTOR

Adult Naturopathic Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

Contact Information:

Name:_____ **Date of First Visit:**_____

Address:_____

City:_____ Province:_____ Postal Code:_____

Home Phone # ( )_____Cell ( )_____

Gender (circle) M F Date of Birth: (DD/MM/YYYY)_____

E-mail Address:_____

Employer:_____ Occupation:_____

Work Phone # ( )_____ Hours worked per week :_____

Do you have private health insurance? **YES** **NO**

Marital Status: **Married** **Separated** **Divorced** **Widowed** **Single** **Partner**

Number of Children:_____ Ages of the children:_____

In case of an Emergency contact:_____

Relationship:_____Emergency Contact # ( ) _____

Address: _____

Medical Care Providers (name, occupation, address, phone #)

Type of Medical Care Provider	Name	Phone Number	Address

Please initial beside the health care provider we have your permission to contact

Can we send you our seasonal newsletter and monthly calendar of events via email. Your email address will not be shared. **YES** **NO**

How did you hear about the clinic?_____

Have you seen a Naturopathic Doctor before?_____

Does any of your family receive Naturopathic treatment?_____

Are you receiving any other type of therapy at this time? If yes please list

_____

Primary Health Concerns:

Please List your main heath concerns (or reasons for visiting the clinic) in order of importance:

1. _____
2. _____
3. _____
4. _____

How long has it been since you have felt really good?_____

Medical History:

Please circle the level of health to the best of your knowledge:

Level of Health as an Infant:	Excellent	Good	Fair	Poor
Level of Health as a Child:	Excellent	Good	Fair	Poor
Level of Health as an Adolescent:	Excellent	Good	Fair	Poor
Level of Health as an Adult:	Excellent	Good	Fair	Poor
Level of Health as a Senior:	Excellent	Good	Fair	Poor

Medical Conditions:
Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/hospitalization	Approximate Date	Is the condition still present?

Current Medications/Supplements: Please list all current medications/supplements

Medication/Supplements	Dosage	Since	Reason

If you need more space please used the back of this sheet or a separate paper.

Past Medication/ Supplements: please list all medication/supplements used in the past 5 years

Medication/Supplementation	Dose/ Length of use	Condition treated

How many times have you taken anti-biotics within the last 5 years _____
Were you frequently given anti-biotics as a child? _____

Allergies: (medications, environmental, food, other items you feel you are sensitive to:

_____

_____

Vaccinations: Please indicate which vaccinations you have received:

Vaccination	Y/N	Adverse Reactions:	Vaccination	Y/N	Adverse Reaction:
(MMR) Measles, Mumps, Rubella			(DPT) Diphtheria, Pertussis, Tetanus		
Haemophilus Influenza B			Chicken Pox		
Rabies			Tetanus		
Hepatitis A			Polio		
Hepatitis B			Flu		

Do you have or use any of the following:

Substance	Circle one	How often? What type or Brand?
Alcohol	YES NO	
Cigarettes	YES NO	
Recreational Drugs	YES NO	
Aspirin/NSAIDS	YES NO	
Laxatives	YES NO	
Ant-acids pills	YES NO	
Diet pills	YES NO	
Coffee	YES NO	

Do you have or use any of the following:

Substance	Circle one	How often? What type or Brand?
Black Tea	YES NO	
Green Tea	YES NO	
Metal Implants	YES NO	Where?
Injections of any kind	YES NO	
Mercury Fillings	YES NO	How many?
Resin Fillings	YES NO	How many?
Other	YES NO	

Screening Tests: Please indicate which of the following tests you have received:

Test	Circle one	How often?
Breast Exams	YES NO NEVER	
Mammogram	YES NO NEVER	
DEXA scan (Bone density)	YES NO NEVER	
PAP test (women only)	YES NO NEVER	
Cholesterol	YES NO NEVER	
Blood glucose	YES NO NEVER	
Complete Blood Count (CBC)	YES NO NEVER	
Vitamin D	YES NO NEVER	
PSA test (men only)	YES NO NEVER	
Stool sample	YES NO NEVER	
Other	YES NO NEVER	

Please indicate if you have had any of the following illnesses:

Illness	Circle one	Illness	Circle one
Shingles	YES NO	Chicken Pox	YES NO
Mumps	YES NO	German Measles	YES NO
Rheumatic fever	YES NO	Mononucleosis	YES NO
Scarlet fever	YES NO	Strep Throat	YES NO
Tuberculosis	YES NO	Whooping Cough	YES NO

Family History:

Please indicate the family history below: ❒ I do not know my family history

Relation	Age	Condition	Cause of death (if deceased)
Paternal Grandmother			
Paternal Grandfather			
Maternal Grandmother			
Maternal Grandfather			
Mother			
Father			
Siblings			
Children			

Life Style:

Rate your current level of health (10 is the best): **1 2 3 4 5 6 7 8 9 10**

Have you experienced any major trauma or loss in the past 5 years? ***YES*** ***NO***

Have you experienced any other trauma or loss in your life? ***YES*** ***NO***

How would you currently rate your level of stress at this time?

Minimal ***Average*** ***Considerable*** ***Unbearable***

Please list the two most stressful events in your life:

1._____ ***2.***_____

How often do you engage in physical activity? (Indicate type, frequency and time of day):

_____

Have you lost any weight lately? **YES** **NO** If YES, how many pounds?_____

Are you concerned about your weight? **YES** **NO**

Are you seeking guidance in nutrition and daily lifestyle? **YES** **NO**

Sleep:

How many hours of sleep do you get each night? _____ nap: _____

Do you wake rested in the morning: ***YES*** ***NO***

Rate your Sleep: **Poor** **Fair** **Good** **Excellent**

Do you fall asleep easy? ***YES*** ***NO***

Do you wake frequently through the night? ***YES*** ***NO*** If YES, why?_____

Do you fall back to sleep easily? ***YES*** ***NO***

Do you have a regular sleep routine? ***YES*** ***NO***

Life Style Continued:

How many hours per day do you spend on the following:

Driving _____ Watching TV _____ Reading _____ In front of a computer _____ Work _____

List some of your hobbies, or things you enjoy doing:_____

Do you have any pets? _____

Please describe any toxins or other work hazards you are/were regularly exposed to (work, home, hobbies, cottage, community, etc.):

_____

How is your house heated?_____ Have you done recent renovations? **YES NO**

Smoker: **YES NO** Smoked for _____ years Amount per Day_____ Year Stopped_____

Are you exposed to second hand smoke? **YES NO**

Your last time out of the country: _____

Diet

Do you consume the following (circle all that apply and indicate frequency):

Fresh Vegetables: _____ Fresh Fruit: _____ Cold-water Fish: _____ Tuna: _____

Canned goods: _____ Pop: _____ Milk: _____ Coffee: _____ Water: _____ Juice: _____

Processed Foods: _____ Microwavable meals: _____ Red meat: _____ Cheese: _____ Chocolate: _____ Aspartame: _____ Deli meats: _____ Fast Food: _____ Margarine: _____

Do you crave (circle all that apply): **Sugar Chocolate Salt Crunchy foods**

other craving you might have: _____

Do you think your eating habits could have an affect on your health? **YES NO**

Personal overview

Please rate your level of commitment to achieving your health goals: (10 =100% commitment)

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

Please list the behaviours or lifestyle habits you currently engage in regularly which you believe support your health?

_____

_____

Please list any behaviours or lifestyle habits you currently engage which you believe are self-destructive to your health?

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the therapeutic protocols that I will be sharing with you?

_____

_____

Lifestyle continue:

Do you have people who will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

_____

_____

What expectations do you have of me person as your physician?

_____

_____

Is there anything else you think is important with regards to your health?

_____

_____

_____

_____

SYSTEMS REVIEW

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer completely as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your appointment. **Please check (✓) "C" if you currently have the symptom or "P" if you have had it in the past year.**

Skin	C	P	Nose & Sinuses	C	P	Cardiovascular	C	P
Rashes			Frequent colds			Angina		
Hives			Nose Bleeds			Murmurs		
Acne			Stuffiness			Chest Pain		
Boils			Hay Fever			Swelling in Ankles		
Psoriasis			Infections			Palpitations, Fluttering		
Dry Skin			**Mouth & Throat**			Last ECG		
Itching			Hoarseness			Other		
Lumps			Gum Problems			**Breast**		
Night Sweats			Difficulty Swallowing			Do you do Self exams		
Other			Dental problems			Lumps		
			Sores			Pain (or tenderness)		

Head	C	P	Mouth & Throat	C	P	Breast	C	P
Tension Headaches			Dryness			Nipple discharge		
Migraine Headaches			Sore Throat			Last Mammogram		
Head Injury			Loss of taste			Other		
Dizziness			Other			**Gastrointestinal**		
Other			**Neck**			Vomiting		
Eye			Lumps			Heartburn		
Impaired vision			Swollen Glands			Change in Appetite		
contact lenses / glasses			Goiter			Frequency of Bowel movements per day	1 2	3 +
			Pain or stiffness			Nausea		
Tearing			**Respiratory**			Vomiting blood		
Dryness			Cough			Belching		
Double vision			Sputum			Passing gas		
Glaucoma			Spitting up blood			Abdominal Pain		
Cataracts			Wheezing			Indigestion		
Blurring			Asthma			Diarrhea		
Light Sensitivity			Bronchitis			Constipation		
Itching			Pneumonia			Blood in stool		
Redness			Pleurisy			Hemorrhoids		
Discharge			Emphysema			Black tarry Stool		
Blind Spot			Pain on Breathing			Jaundice (yellow skin)		
Other			Shortness of Breath			Liver disease		
Ears			Positive tuberculin test			Gall Bladder disease		
Impaired hearing			Last TB test			Food allergy		
Earache			Last chest X-ray			Hiatus hernia		
Dizziness			Other			Other		

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Ears	C	P	Endocrine	C	P	Male Reproduction	C	P
Discharge			Heat/cold intolerance			Hernia		
Infections			Thyroid trouble			Testicular mass		
Excessive wax			Excessive thirst			Testicular Pain		
Other			Excessive hunger			Impotence		
Urinary			Excessive sweating			Premature ejaculation		
Pain on urination			Diabetes			Venereal Disease		
Increased frequency			Other			Discharge of sores		
Frequency at night			**Emotional**			Sexually active		
Inability to hold			Depression			Last prostate exam		
Frequent infections			Extreme anger			Last PSA levels		
Kidney stones			Anxiety			Other		
Blood in urine			Nervousness			**Female Reproductive**		
Reduced urine flow			Phobias			Age of first menses		
Other			Insomnia			Last menstrual period		
Neurological			Drug Abuse			Length of cycle		
Fainting			Memory problems			Number of days of menses		
Seizures/Convulsion			Concentration problems			Bleeding between periods		
Paralysis			Other			Irregular cycles		
Muscle weakness			**Musculoskeletal**			PMS		
Numbness/tingling			Broken bones			Heavy flow		
Loss of memory			Muscle spasms/cramps			Painful menses		
Involuntary movements			Weakness			Menopause		
Loss of balance			Joint swelling			Age of onset		
Speech problems			Backache			Hormone therapy		
Other			Other			Last gynecological exam		

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Peripheral vascular	C	P
Cold hands/feet		
Deep leg pain		
Varicose veins		
Leg cramps		
Extremity numbness		
Extremity swelling		
Extremity ulcers		
Other		

Blood/Lymphatic	C	P
Anemia		
Easy bleeding/bruising		
Past transfusions		
Lymph node swelling		
Other		

Female Reproductive	C	P
Number of Pregnancies:		
Number of live births		
Number of miscarriages		
Difficulty conceiving		
Vaginal discharge		
Vaginal Itching		
Sexually active		
Pain with intercourse		
Other		

Thank you for completing this extensive health record. Your time is appreciated!