

Naturopathic Adult Intake Form
(please print clearly)

Name _____ **Date** _____

Date of birth _____ (M/D/Y) **Sex:** M F

Address: _____

Telephone Number:
Home: _____ **Work:** _____

May we leave messages relating to your visits? Y / N

Emergency contact:
Name: _____ **Phone Number:** _____

Relation: _____

How did you hear about us? _____

Other health care providers you are seeing:

1. _____

Phone: _____ **Fax:** _____

2. _____
Address: _____
Phone: _____ **Fax:** _____

3. _____

Phone: _____ **Fax:** _____

E-mail Address: _____

What are your health concerns, in order of importance to you:

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

If you are female are you currently pregnant? Yes No (Please circle one)

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please list any serious illnesses, injuries, conditions, hospitalizations or events that had a significant impact on you:

| | |
|-------|--------------------|
| _____ | Date: _____ |
| _____ | Date: _____ |
| _____ | Date: _____ |
| _____ | Date: _____ |
| _____ | Date: _____ |
| _____ | Date: _____ |
| _____ | Date: _____ |
| _____ | Date: _____ |

Do you have any allergies (environmental, medicines, foods, etc.)

Please list all current medications (prescription, over the counter, vitamins, herbs)

Please list past prescription medications:

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (please circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/ implants/ injections
Alcohol-how much: day/week _____

Tobacco: form and amount/day _____

Caffeine: form and amount/day _____

Recreational drugs what/how often _____

Please indicate what immunizations you have had

| | |
|--|-------------------|
| _____ DPT (diphtheria, pertussis, tetanus) | _____ Hepatitis A |
| _____ Haemophilus influenza B | _____ Hepatitis B |
| _____ Tetanus booster; when? | _____ Polio |
| _____ MMR (measles, mumps, rubella) | _____ Smallpox |
| _____ "flu" | _____ Other |

Please indicate if any caused adverse reactions:

Do you get regular screening tests done by another doctor? (blood tests, pap, etc)
Y / N

Diet

Do you have any dietary restrictions (religious, vegetarian/vegan, etc?)

Please describe a typical day's diet:

Breakfast _____

Snacks _____

Lunch _____

Snacks _____

Dinner _____

Snacks _____

Beverages _____

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

| | Who? | | Who? |
|---------------------|------|-----------------------|------|
| Allergies | | Depression | |
| Asthma | | Other Mental Illness | |
| Heart Disease | | Kidney Disease | |
| High blood pressure | | Drug Abuse/Alcoholism | |
| Cancer | | Other | |
| Diabetes | | Other | |

_____ I don't know my family medical history

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y/N What do you do for exercise, how much and how often?

Are you exposed to significant tobacco smoke (work, home, etc?) Y/N

Are you frequently exposed to animals (work, pets, etc?) Y/N

How is your home heated?

**Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc)?
Please describe.**

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life?

Least stressful

Most stressful

1 2 3 4 5 6 7 8 9 10

(Please circle one)

How well do you handle these stresses?

Is there anything that you feel is important that has not been covered?

For file use only.