#

# Naturopathic Intake Form

**Dr. Caitlin Shea, Naturopathic Doctor**

**Patient Information**

Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_ Occupation: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

City: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Postal Code: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (D): \_\_\_\_\_\_\_ (M): \_\_\_\_\_\_\_ (Y): \_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_

Preferred Pronoun He She Other: \_\_\_\_\_\_\_

How would you identify your gender identity:  Female  Male  Transgender  Alternative  Prefer not to answer

Phone (home): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone (business): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (mobile): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_e-mail: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message relating to your visit? Y / N

Marital Status: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Number of children: \_\_\_\_\_\_\_\_ Ages of children: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about the Clinic? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other health care providers you are seeing:

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Specialty: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_ Phone (\_\_\_\_\_\_) \_\_\_\_\_\_\_\_\_\_\_\_

Date of last visit: \_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_ Date of last visit: \_\_\_\_\_\_\_\_\_\_\_

**Health Goals**

|  |
| --- |
| Please list most important health concerns and goals in their order of significance: |
| * 1.
 |
| * 1.
 |
| * 1.
 |
| * 1.
 |
| * 1.
 |

Are you currently pregnant? (Please circle one) Yes / No Due Date\_\_\_\_\_\_\_\_\_\_\_\_

Are you currently lactating? (Please circle one) Yes / No

**Medical History**

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

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have allergies (Medications, environmental, etc.)?

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, etc.)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ 6. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list past prescription medications/natural health products:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other Pain Relievers Y N P

Laxatives Y N P Antacids Y N P Diet Pills Y N P

Birth control Y N P Type (please circle): Pills / Implants / Injections

Antibiotics Y N P Approximate number of prescriptions: \_\_\_\_\_\_\_\_\_\_\_\_

Alcohol Y N P How much/day or week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco Y N P Form and amount/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine Y N P Form and amount/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drugs Y N P What and how often \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate what immunizations you have had:

 DPT (diptheria, pertussis, tetanus)  Haemophilus influenza B  Hepatitis A

 Tetanus booster; when? \_\_\_\_\_\_\_\_\_\_\_\_  "Flu"  Hepatitis B

 MMR (measles, mumps, rubella)  Polio  Smallpox

Others \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate if any caused adverse reactions: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

Last time you had blood work done \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Personal and Family History**

Please indicate if this condition applies to you or one of your family members and indicate who the condition applies to (Self, Father, Mother, Sibling, Grandparent, Your Child). Indicate if the condition is Resolved or Current.

|  |  |  |  |
| --- | --- | --- | --- |
| Cancer |   | Heart disease |   |
| Allergies |   | Osteoarthritis |   |
| Diabetes |   | Rheumatoid Arthritis |   |
| Multiple Sclerosis |  | Mental Illness |  |
| Asthma |  | Psoriasis |  |
| Eczema |  | Alcoholism  |  |

**Diet**

Do you have any food allergies or intolerances? Please list.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**Review of Systems**

Please check off any condition that you have experienced in the past or present. Make a **√** for current, **X** for past:

|  |  |  |  |
| --- | --- | --- | --- |
| Skin: Rashes  eczema Psoriasis  acne Itching  lumps Dry  moist Easy bruising  Colour changes | Nails: Colour changes Fungal infections Brittle  | Head: Migraines Headaches Dizziness | Eyes: Pain Tearing dryness Blurring Discharge redness Cataracts Glaucoma Itching |
| Ears: Impaired hearing Earache Dizziness Discharge Infections Ringing | Nose and sinus: Frequent colds Nose bleeds Stuffiness Hay fever Sinus problems | Mouth and throat: Frequent sore throat Gum problems Hoarseness Dental cavities loss of taste | Neck: Lumps Swollen glands Pain or stiffness Enlarged thyroid |
| Lungs: Cough Phlegm Spitting up blood Wheezing Difficulty breathing Shortness of breath Pain on breathing | Cardiovascular: Heart disease High blood pressure Murmurs  Palpitations Chest pain | Peripheral vascular: Deep leg pain Cold extremities Varicose veins Extremity swelling/ulcers | Urinary: Pain Nightly urination Inability to hold urine Blood in urine Urgency Infections |
| Upper gastrointestinal: Heartburn Indigestion Nausea Vomiting Belching Passing gas Stomach pain | Lower gastrointestinal: Constipation Diarrhea Blood in stool Mucous in stool Hemorrhoids Black stools | Musculoskeletal: Joint pain/stiffness Muscle pain/stiffness Weakness Back pain Broken bones | Neurologic: Fainting Seizures Paralysis Numbness/tingling Loss of balance Muscle weakness Involuntary movement Speech problems Memory loss |
| Endocrine: Fatigue Heat/cold intolerance Thyroid problems Excess: thirst/hunger/sweatingSleep: Difficulty falling asleep Frequent wakingHours asleep:Do you wake rested? Y/N | Women's health: Fibrocystic breasts Breast lumps Breast tenderness Nipple discharge Vaginal discharge Vaginal itching Difficulty conceivingNumber of pregnancies:\_\_Number of live births:\_\_Date of last PAP:\_\_\_\_\_\_Type of birth control: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ | Women's menstrual cycle: Painful periods PMS Excessive menstrual flow Irregular periodsAge of menarche:\_\_\_Cycle length:\_\_\_ | Men's health: Hernias Testicular masses/pain Enlarged prostate |

**Environment**

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

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How would you describe the emotional climate of your home?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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How stressful is your work, or other aspects of your life? How well do you handle these stresses?

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

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Thank you for completing this form.