#126, 6104-172 Street
Edmonton AB T6M 1G9
780-489-7799 ~ www.wellness-within.ca

Adult Intake Form

As your Naturopathic Doctor, it is important that I am aware of your current health status, your complete medical history, as well as what areas of your health you would like to see change in the future. Please complete this form as thoroughly as possible, as your responses will greatly assist in the development of a personalized treatment plan.

***Please bring all of the completed forms in this package with you to your first visit.**

Name: ____________________ Today's date: __________

Date of Birth: _______/_______/__________ Age: _______ Gender: Male: ❐ Female: ❐
Month Day Year

Occupation: ____________________ AHC# __________

Live with: ❐ spouse ❐ partner ❐ children (how many? ______) ❐ roommate ❐ parents ❐ alone

CONTACT INFORMATION *Please inform us if your contact information changes*

Address: ________________________________

City: ______________ Province: __________ Postal Code: __________

Phone (H): ______________ (Bus.): ______________ (Cell): ______________

E-mail: ____________________

❐ Check here if you would prefer NOT to receive our Wellness e-newsletter

EMERGENCY CONTACT

Name: ____________________ Relationship: __________

Phone (H): ______________ (Bus.): ______________ (Cell): ______________

HEALTHCARE PROVIDERS:

Primary Health Care Physician: ____________________ Phone: __________

When was your last physical exam? ____________________

Are you currently under the care of a specialist? ❐ Y ❐ N

Name: ______________ Specialty: ______________ Phone: __________

Are you currently under the care of alternative health care providers? ❐ Y ❐ N

Name: ______________ Specialty: ______________ Phone: __________

Name: ______________ Specialty: ______________ Phone: __________

CONTEXT OF CARE

What about Naturopathic Medicine interests you?

What 3 expectations do you have from **THIS VISIT**?

What are your **LONG TERM** health goals?

What expectations do you have of me personally as your naturopathic doctor?

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Please rate from 1 to 10, 10 being 100 % committed).

1 2 3 4 5 6 7 8 9 10

What behaviors or lifestyle habits do you currently engage in regularly that you believe **SUPPORT** your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are **NOT** supportive of optimal health?

What potential obstacles do you foresee in addressing the lifestyle factors or in complying with diet or supplement suggestions?

Who do you know that will sincerely support you consistently with the potential lifestyle changes you will be making?

How would you describe your general state of health?

HEALTH CONCERNS

Please list your health concerns, in order of greatest importance to you.

1. ___________________________________ 5. ___________________________________
2. ___________________________________ 6. ___________________________________
3. ___________________________________ 7. ___________________________________
4. ___________________________________ 8. ___________________________________

Are there any traumatic life events you've experienced (physical/ mental/ emotional) that you feel may be associated with your current health concerns? ____

VITAMINS AND SUPPLEMENTS

Please list all vitamin/mineral supplements, herbs, and homeopathic remedies you are currently taking:

Supplement (include brand name)	Total daily dose	Reason for Use	Duration of Use

PRESCRIPTION MEDICATIONS

Please list all current medications and indicate the total dosage taken in one day:

Current Medications	Total daily dose	Reason for Use	Duration of Use

Please list any medications used in the past 12 months, but have now discontinued:

Medications in past 12 months	Total daily dose	Reason for Use	Duration of Use

Are there any medications that you have used for more than 5 years of your life, which you have not already mentioned?

____

Number of times on antibiotics in the past 10 years: ___________

Do you regularly use any of the following? ❒ Laxatives ❒ Sleeping pills ❒ Antacids ❒ Painkillers ❒ Diet pills

If so, please indicate type, frequency, and amount: ____

MEDICAL HISTORY

How would you describe your general health during childhood? ❐ Excellent ❐ Fair ❐ Poor ❐ Very Poor

Which childhood illnesses have you had?

❐ Asthma
❐ Rheumatic Fever
❐ Rubella (German Measles)
❐ Chicken Pox
❐ Scarlet Fever
❐ Whooping Cough
❐ Mumps
❐ Roseola
❐ Measles
❐ Polio
❐ Other: _______________

Which vaccinations have you had?

❐ HBV (hepatitis B)
❐ MMR (measles, mumps, rubella)
❐ Hib (*Haemophilus influenza b*)
❐ DPT (diphtheria, tetanus, pertussis)
❐ Hepatitis
❐ Tetanus Booster
❐ Polio
❐ VZV (chicken pox)
❐ Meningococcal
❐ Smallpox
❐ Typhus
❐ Influenza (flu shot)
❐ HPV
❐ Other: _______________

Adverse Reactions

Please describe any adverse reactions, allergies, or sensitivities you have experienced with prescription or over-the- counter medications, recreational drugs, vaccinations (childhood, travel, flu, hepatitis), or natural medicines (herbs, vitamins, minerals, homeopathics)

Name of drug, vaccine or natural medicine	Describe the reaction

Past Surgeries and Tests

Please list any surgeries and the year in which they occurred (ie. Appendix, gallbladder, heart, hernia, mastectomy, hysterectomy ,sinus, tonsils, ear tubes, etc):

____

____

Please list any significant tests and the year in which they occurred (ie. Biopsies, ECG, echocardiogram, mammogram, colonoscopy, gastroscopy, CT scan, MRI, ultrasounds, x-rays, etc):

____

____

Please list any hospitalizations and the year in which they occurred:

____

____

Please list any major injuries or traumas you have suffered and indicate the year they occurred: _______________

____

____

Dental Work: How many silver amalgam fillings do you have? ________ How many root canals? ________

FAMILY MEDICAL HISTORY

Relation	Significant Health Concerns/Diagnoses	If Deceased, cause & age at death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings		

NUTRITIONAL HISTORY

Describe a typical day's diet:

Breakfast: ______________________________

Lunch: ______________________________

Dinner: ______________________________

Snacks: ______________________________

Water intake (total quantity): ______________________________

Other fluids (what & total quantity): ______________________________

What is the primary source of your drinking water? ❒ Tap ❒ Well ❒ Bottled (spring) ❒ Filtered ❒ Distilled

Is there anything about your diet you would like to change? ______________________________

____

On average how many meals do you eat per day? 1 2 3 4 5 >5

Which is usually your largest meal? ❒ Breakfast ❒ Lunch ❒ Dinner

List any foods that you crave regularly: ______________________________

List any foods you exclude from your diet: ______________________________

Do you follow a specific diet regime? ❒ Vegetarian ❒ Vegan ❒ Other ______________________________

Do you consume organic foods? ❒ Never ❒ 1-3x/wk ❒ 3-5x/wk ❒ 5-7x/wk ❒ Daily ❒ Several times/day

Do you monitor your intake of ❒ Fat ❒ Salt ❒ Sugar ❒ Fiber ❒ Carbohydrate ❒ Protein

Any known food allergies/ intolerances/ sensitivities? ______________________________

Do you experience binge eating or drinking? ❒ Yes ❒ No Compulsive eating? ❒ Yes ❒ No

Any history of nutrient deficiency (ie. Iron, folic acid, B12, zinc, etc)? ______________________________

LIFESTYLE

Educational Background: ____

How many hours/ week on average do you work? ___________ Do you enjoy your job? ❒ Y ❒ N

Career goals? ____

How many times per week do you exercise? ❒ Never ❒ < 1/wk ❒ 1-3/wk ❒ 3-5/wk ❒ >5/wk

What types of exercise do you do? ____

How long do you spend exercising each time? ____

Please indicate the amount of time you spend doing the following activities on a typical day:

Activity	Time (Hrs)	Activity	Time (Hrs)
Computer related work		Relaxing	
Driving		Sleeping	
Eating		Taking public transit	
Exercising		Time spent inside buildings	
Listening to music		Time spent outdoors	
Personal Hygiene		Watching TV	
Reading		Working	

Energy level (please circle): Low 1 2 3 4 5 6 7 8 9 10 High

Do you experience fatigue? Y / N Hyperactivity? Y / N Restlessness? Y / N

Do you sleep well? Y / N Do you wake feeling well rested? Y / N

How many hours/ night do you typically sleep? _________

Do you have troubles falling asleep at night? Y / N If yes, Why? ____________________________________

Do you experience nightmares? Y / N Themes:____

Do you experience recurrent dreams? Y / N Themes:____

Do you wake throughout the night? Y / N If Yes, Why? ____

How many times/ night? _______ Do you wake at the same time every night? Y / N If Yes, what time(s)?________

Do you snore? Y / N Occurrence of sleepwalking: Y / N If Yes, Frequency: ______________________

How many hours of direct sunlight are you exposed to each week in the Summer? __________ Winter? ____________

Do you use sunscreen regularly? ❒ Yes ❒ No, If No Why? ____

Do you smoke? ❒ Yes (# packs per day ______ , # of years ______) ❒ Never smoked

Smoked in the past (# of years _____; # packs per day ______; Year that you quit ________)

Regularly exposed to second hand smoke? Y / N ❒ Use chewing tobacco

Do you use recreational/street drugs? ❐ Yes ❐ No ❐ In the past

If yes, which drugs, how often, and for how long? ____

Have you ever had a problem with an addiction? Y / N If Yes, Please specify (i.e. alcohol, food, drug, gambling, etc):
____

When was your last vacation? ____

Travel history (please include destinations and dates of recent travel):
____
____
____

Mental/Emotional:

❐ Prolonged sadness/grief	❐ Easily angered	❐ Mental illness	❐ Panic attacks
❐ Anxiety/Nervousness	❐ Indecision	❐ Mood swings	❐ Memory problems
❐ Depression	❐ Irritability	❐ Phobia	❐ Confusion/ poor comprehension
❐ Poor Concentration	❐ Stuttering or Stammering		❐ Learning Disabilities

What are the major stresses in your life? (i.e. financial, job related, health, family, spiritual)
1.____
2.____
3.____
4.____

Has there been an event or illness from which you have never fully recovered from? ______________________________
____
____

Indicate your current stress level on a scale of 1-10:

Low 1 2 3 4 5 6 7 8 9 10 High

How do you deal with stress? ______________________ Does this approach help sufficiently? ______________________

How would you describe your spirituality? ____

What do you do for recreation? (i.e. What are your hobbies and interests?) ____________________________________
____

ENVIRONMENTAL EXPOSURES

Which of the following are you routinely exposed to?

❒ Forced Air	❒ Radiant Heat	❒ Gas Heat	❒ Oil Heat	❒ Food cooked on BBQ
❒ Wood Stove	❒ Air Conditioning	❒ Electric Blanket	❒ Gas Fumes	❒ Microwave
❒ Feather Pillow	❒ Heated Waterbed	❒ Computer Screen	❒ Factory Fumes	❒ Mould/mildew
❒ Air Pollution	❒ Hydro Towers	❒ Chemical Spray	❒ Pesticides	❒ Paint fumes
❒ Makeup/body creams	❒ Perfumes/Colognes	❒ Nail Polish	❒ Electric Heat	❒ Air fresheners
❒ Cleaning Products	❒ Chlorinated Water	❒ Other (Specify): ___________________________________		

Do you have pets in your home? ❒ Yes ❒ No Type of pets? ____

Is your home or work environment excessively ❒ Damp ❒ Dry ❒ Hot ❒ Cold

Age of home? _____

What is the flooring in your home? ____________________

Do you have any environmental allergies? ❒ Yes ❒ No If so, to what? __________________________________

REVIEW OF SYSTEMS

Height: ___________ Weight: ___________ Weight 1 year ago: __________ Desired weight: __________

If your present weight is different than your desired weight, how long has it been since you were at your desired weight? ___________

Have you had an unexplained loss or gain of weight of 10 lbs or more in the past 6 months? ❒ Yes ❒ No

*Please place a checkmark if you are currently experiencing or have experienced any of the following:

Immune:

❒ Chronic infections	❒ Shingles	❒ Cold sores	❒ Frequent sore throats
❒ Frequent antibiotic use	❒ Frequent colds/flus	❒ Swollen glands/nodes	❒ Slow wound healing

Neurological:

❒ Paralysis	❒ Muscle weakness	❒ Vertigo	❒ Loss of balance
❒ Numbness	❒ Tingling	❒ Loss of memory	❒ Lack of coordination
❒ Seizures/Epilepsy	❒ Concussion	❒ Loss of sensation	❒ Slurred Speech

Endocrine:

❒ 20 lbs change in weight in the last year	❒ Generally feel hot	❒ Generally feel cold
	❒ Mental dullness	❒ Water retention
❒ Sluggish after eating	❒ Sluggish after coffee	❒ Frequent thirst
❒ Hypoglycemia (low blood sugar)	❒ Poor concentration	❒ Frequent hunger

Skin, Hair and Nails:

❒ Rashes/Hives	❒ Itching	❒ Hair loss	❒ Night sweats
❒ Lumps/Abcesses	❒ Strong body odour	❒ Brittle nails	❒ Warts
❒ Excessive perspiration	❒ Dry skin	❒ Eczema/psoriasis	❒ Thinning hair
❒ Boils	❒ Recent moles	❒ Flushing/ hot flashes	❒ Easy Bruising
❒ Acne	❒ Excess hair growth	❒ Change in the size, shape, colour of a mole or freckle	
❒ Bleeding			

Head, Eyes, Ears, Nose and Throat:

❒ Headaches
❒ Migraine headaches
❒ Visual disturbances
❒ Colour blindness
❒ Near sighted
❒ Far sighted
❒ Astigmatism
❒ Eye pain/strain
❒ Voice changes
❒ Poor night vision
❒ Dry eyes
❒ Excessive tearing
❒ Blurry vision
❒ Swollen/Reddened eyelid
❒ Bags/dark circles under eyes
❒ Nose bleeds
❒ Hoarseness
❒ Earaches
❒ Impaired hearing
❒ Ringing in ears
❒ Sinus infections
❒ Itchy ear canal
❒ Excessive ear wax
❒ Drainage from ear
❒ Loss of taste/smell
❒ Polyps
❒ Poor sense of smell
❒ Gum problems
❒ Cavities
❒ Throat hoarseness
❒ Facial pain/tics
❒ Sores in mouth
❒ Teeth grinding
❒ Post nasal drip
❒ Canker sores

Respiratory System:

❒ Shortness of Breath
❒ Chronic cough
❒ Wheezing
❒ Bronchitis
❒ Asthma
❒ Pain while breathing
❒ Emphysema/COPD
❒ Difficulty breathing while lying down
❒ Coughing blood
❒ Throat phlegm

Cardiovascular System:

❒ High blood pressure
❒ Low blood pressure
❒ Irregular heartbeat
❒ Swelling of limbs
❒ Rapid/pounding heartbeat
❒ Heart attack
❒ Phlebitis
❒ Chest pain
❒ Dizziness
❒ Stroke
❒ Pacemaker
❒ Varicose veins
❒ Heart murmurs
❒ Fainting
❒ Artificial valve
❒ Cold hands or feet
❒ Chest pain

Gastrointestinal System:

❒ Indigestion
❒ Heartburn
❒ Bad breath
❒ Trouble swallowing
❒ Nausea
❒ Bloating
❒ Colon trouble
❒ Vomiting
❒ Black stool
❒ Abdominal pain
❒ Diarrhea
❒ Constipation
❒ Chronic laxative use
❒ Known parasites
❒ Undigested food in stool
❒ Jaundice
❒ Hard stool
❒ Floating stool
❒ Blood in stool
❒ Rectal pain
❒ Gallbladder problems
❒ Gas or burping
❒ Mucus in stool
❒ Change in appetite
❒ Change in thirst
❒ Hemorrhoids
❒ Itching around rectum
❒ Incomplete bowel movements

How often do you have a bowel movement? ______________________________

Genito-urinary System:

❒ Frequent urination
❒ Urgency on urination
❒ Pain on urination
❒ Blood in urine
❒ Mucus in urine
❒ Incontinence
❒ Awaken to urinate
❒ Strong urine odour
❒ Bladder infections
❒ Kidney stones
❒ Kidney infection
❒ Strain to urinate

Muscle, Bones and Joints:

❒ Neck pain
❒ Back pain
❒ Swelling
❒ Muscle pain
❒ Muscle weakness
❒ Stiffness
❒ Arthritis
❒ Bursitis
❒ Night cramps
❒ Artificial joint
❒ Other pain
❒ Fractures/dislocations/sprains

Male Reproductive System:

❒ Hernia
❒ Discharges or sores
❒ Testicular pain
❒ Testicular mass
❒ Sexual difficulties
❒ Painful erections
❒ STD/ STI
❒ Impotence
❒ Low sexual drive
❒ Prostate problems

What is your sexual orientation? ______________________________

Female Reproductive System:

❒ Vaginal discharge
❒ Vaginal dryness
❒ Vaginal itching
❒ Odour to discharge
❒ Recurrent yeast infections
❒ Irregular periods
❒ Heavy periods
❒ Clots during period
❒ Light periods
❒ Missed periods
❒ Abnormal PAP tests
❒ Sores, growths, lumps
❒ Infertility
❒ Pain with Intercourse
❒ Bleeding between periods
❒ Low sex drive
❒ STD/ STI
❒ Fibroids
❒ Ovarian Cysts
❒ Endometriosis

PMS symptoms:

PMT-A
❒ Nervous Tension
❒ Irritability
❒ Mood Changes
❒ Anxiety
❒ Insomnia
❒ Paranoia

PMT-C
❒ Headache
❒ Craving sweets
❒ Increased Appetite
❒ Heart pounding
❒ Dizziness or faint
❒ Fatigue

PMT-D
❒ Depression
❒ Forgetful
❒ Crying
❒ Confusion
❒ Clumsy
❒ Withdrawl

PMT-H
❒ Weight Gain
❒ Abdominal Bloating
❒ Swelling of extremities
❒ Breast Tenderness
❒ Water retention

PMT-P
❒ Joint Pain
❒ Low back pain
❒ Abdominal pain
❒ Headaches

Breast Health:

❒ Fibrocystic breasts
❒ Lump
❒ Breast tenderness
❒ Dry skin on nipple
❒ Nipple discharge
❒ Lactation
❒ Skin puckering

Age of first menses: _______________ Age of last menses (menopausal):_____________

Length of cycle (time between the onset of one period to the onset of the next): _____________

For how long do you usually bleed on average? _______ days

How many pads/ tampons do you use on the heaviest day of your cycle? ___________

Date of last PAP: _________________________

What is your sexual orientation? ___________________ Are you sexually active? ❒ Yes ❒ No

Do you practice birth control? ❒ Yes ❒ No What type of birth control currently used? _________________

What types of birth control have you used in the past? ____

Are you pregnant? ❒ Yes ❒ No Are you trying to conceive? _________________

Number of: Pregnancies: _____ Abortions: _____ Miscarriages: ______ Live births: ______

Do you perform monthly self-breast exams? ❒ Yes ❒ No
Are you familiar with how to perform a self-breast exam? ❒ Yes ❒ No

Date of last breast exam: _____________ Do you have regular mammograms? ❒ Yes, how often ____ ❒ No

Additional comments/ Anything you would like to share that hasn't already been covered: ___________________
____
____
____

How did you hear about our clinic? ____

SIGNATURE

I, _______________________ attest that the information provided is true and accurate to the best of my knowledge.

Signature: ______________________________ Date: ____________