Nature's Touch
NATUROPATHIC CLINIC

CONFIDENTIAL ADULT INTAKE FORM

(please print clearly)

Name:_____
Date _____

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

–

E-mailAddress:_____
Empower your Health with monthly health tips by Nature's Touch: YES NO

Telephone number: Home:_____ Work:_____
May we leave messages or email relating to your visits? YES. NO

Emergency contact: Name: _____
Phone number:_____ Relation:_____

****Naturopathic medicine works the best when the doctor has a complete picture of the physical, emotional and mental symptoms. Therefore, please take the time to thoroughly complete this health questionnaire.****

How did you hear about our Clinic?
_____
If referred, who were you referred by:_____

Other health care providers you are seeing:

1. _____
2. _____
3. _____

Context of Care

1. Why did you choose to come to this clinic?

_____
_____

2. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

3. What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)

_____
_____
_____

4. What behaviours or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)

_____
_____
_____

Health Concerns:
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:
Do you have any allergies (medicines, environmental, etc.)?

_____
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____
_____
_____
_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)
Alcohol—how much/day or week _____
Tobacco—form and amount/day_____
Caffeine—form and amount/day_____
Recreational drugs—what and how often_____

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

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

_____
_____
_____

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

_____
_____
_____

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

Please indicate which family member
Allergies: _____
Asthma:_____
Heart Disease:_____
High Blood Pressure:_____
Cancer:_____
Diabetes:_____
Mental Illness:_____
Drug Abuse/Alcoholism:_____
Kidney Disease:_____
Other:_____
□ I don't know my family medical history

Environment
Occupation:_____
Hobbies:_____

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

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

Review of Systems

Point Scale:
0-*Never or almost never have the symptom*
1-*Occasionally have it, effect is not severe*
2-*Occasionally have it, effect is severe*
3-*Frequently have it, effect is not severe*
4-*Frequently have it, effect is severe*

Head _____ Headaches _____ Faintness _____ Dizziness _____ Insomnia Total _____	Digestive Tract _____ Nausea, vomiting _____ Diarrhea _____ Constipation _____ Bloated feeling _____ Belching, passing gas _____ Heartburn _____ Intestinal/stomach pain Total _____
Eyes _____ Watery or itchy eyes _____ Swollen, reddened or sticky eyelids _____ Bags or dark circles under eyes _____ Blurred or tunnel vision Total _____	Joints/Muscle _____ Pain or aches in joints _____ Arthritis _____ Stiffness or limitation of movement _____ Feeling of weakness or tiredness _____ Pain or aches in muscles Total _____

Ears _____ Itchy ears _____ Earaches, ear infections _____ Drainage from ear _____ Ringing in ears, hearing loss Total _____	Weight _____ Binge eating/drinking _____ Craving certain foods _____ Excessive weight _____ Water retention _____ Underweight _____ Compulsive eating Total _____
Nose _____ Stuffy nose _____ Sinus problems _____ Hay fever _____ Sneezing attacks _____ Excessive mucus formation Total _____	Energy/Activity _____ Fatigue, sluggishness _____ Apathy, lethargy _____ Hyperactivity _____ Restlessness Total _____
Mouth/Throat _____ Chronic coughing _____ Gagging, frequent need to clear throat _____ Sore throat, hoarseness, loss of Voice _____ Swollen or discoloured tongue, gums, lips _____ Canker sores Total _____	Mind _____ Poor memory _____ Confusion, poor comprehension _____ Difficulty in making decisions _____ Stuttering or stammering _____ Slurred speech _____ Learning disabilities _____ Poor concentration _____ Poor physical coordination Total _____
Skin _____ Acne _____ Hives, rashes, dry skin _____ Hair loss _____ Flushing, hot flashes _____ Excessive sweating Total _____	Emotions _____ Mood swings _____ Anxiety, fear, nervousness _____ Anger, irritability, aggressiveness _____ Depression Total _____
Heart _____ Chest pain _____ Irregular or skipped heartbeat _____ Rapid or pounding heartbeat Total _____	Other _____ Frequent illness _____ Frequent or urgent urination _____ Genital itch or discharge Total _____
Lungs _____ Chest congestion _____ Asthma, bronchitis _____ Shortness of breath _____ Difficulty breathing Total _____	Grand Total Total _____

**Thank you for taking the time to fill out this intake form.
All information will remain confidential.**