**Adult Health Intake**

|  |  |
| --- | --- |
| **Patient Information** |  |
| Date |  |  |  |  |
| First Name |  | Last Name |  |  |
| How would you like to be addressed? |  |
| Address |  | City |  | Postal Code |  |
| Phone |  | Cell |  | Email |  |  |
| Age |  | DOB: (yy/mm/dd) |  | Gender |  |
| Preferred Form Communication | 🞏Phone | 🞏Email |  |  |
| Occupation |  | Employer |  |  |
| Emergency Contact |  | Relation |  | Number |  |
| How did you find out about our office? |  |

**Current Health Information**

|  |
| --- |
| **Health concern/problems that brought you in?** |
| 1  | 2 |
| 3 | 4 |
| Is a physician treating you currently? | 🞏Yes | Name |  |
|  |  | 🞏 No | Phone |  |
| Are you seeing any other medical practitioners? | 🞏Yes | ⬜No |
| Name |  | Treatment |  |  |
| Name |  | Treatment |  |  |
| Do you feel that your general state of health? | 🞏excellent | 🞏good | 🞏average | 🞏poor |
| Energy level(10 best) | /10 | Best time of day |  |  |
| Weight | Current | One year ago |  | Ideal |
| Height |  |  |  |  |
| List 3 most significant, stressful event in your life and dates |
| 1 |  |  |  | Date |
| 2 |  |  |  | Date |
| 3 |  |  |  | Date |
| 4 |  |  |  | Date |

**Medical History**

**Check the following conditions apply to you? PAST AND PRESENT**

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| 🞏Allergies | 🞏Weight Problems | 🞏Stroke | 🞏Sexually Transmitted Infection | 🞏Asthma |
| 🞏Gallstones  | 🞏Cancer | 🞏Eczema | 🞏Gout | 🞏Epilepsy |
| 🞏Psoriasis | 🞏Arthritis | 🞏Migraine | 🞏Miscarriage | 🞏Ear Infections |
| 🞏Thyroid Problems | 🞏Pneumonia | 🞏Varicose Veins | 🞏Strep throat | 🞏Anemia |
| 🞏Diabetes | 🞏Hay fever | 🞏High blood pressure | 🞏Malaria | 🞏Numbness/tingling |
| 🞏Measles | 🞏MRSA | 🞏Rheumatic fever | 🞏Tuberculosis | 🞏Cold hands/feet |
| 🞏Mumps | 🞏Fainting | 🞏Warts | 🞏Chicken pox | 🞏Poor memory |
| 🞏Mononucleosis | 🞏Whooping cough | 🞏Balance problems | 🞏Depression | 🞏Hemerroids |
| 🞏Yeast Infections | 🞏Scarlet fever | 🞏Ringing in ears | 🞏Parasites | 🞏Mental illness |
| 🞏Sinusitis | 🞏Jaundice | 🞏Blood in stool | 🞏Abuse | 🞏Canker sores |
| 🞏Herpes | 🞏Acne | 🞏Heart disease | 🞏Headaches | 🞏Tonsillitis |
| 🞏Alcoholism | 🞏Visual problems | 🞏 Other |  |  |
| Are there any of these from which you feel you have never been well since? |  |
| Please list any known allergies (Environmental, Medications): |  |
| Please list any known food sensitivities: |  |
| Please list any previous surgeries and hospitalizations (including dates):  |  |
| Which of the following do you currently use?  | Please indicate how much, how often and for how long. |
| **🞏**Alcohol | **🞏**Tobacco | **🞏**Hormones | **🞏**Coffee | **🞏**Tylenol |
| **🞏**Laxative | **🞏**Sedatives | **🞏**Antacids | **🞏**Recreational drugs | **🞏**Aspirin |

**Medications**

|  |
| --- |
| **Dosage, reason for taking, duration use** |
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |

**Supplements**

|  |
| --- |
| **Dosage, reason for taking, duration use** |
| 1. | 2. |
| 3. | 4. |
| 5. | 6. |  |
| What do you feel is your weakest organ system and why? (e.g. digestive, cardiovascular, immune, etc.) |
|  |

**Family History**

|  |
| --- |
| **List health conditions for family members** |
| Mother  |  |
| Father |  |
| Siblings |  |
| Grandparents |  |
| Extended family |  |

**Personal Habits**

|  |  |
| --- | --- |
| What are your main interests or hobbies? |  |
| What do you worry about most in your life? |  |
| What do you enjoy most in your life? |  |
| Currently living with? |
| **🞏**children | **🞏**spouse | **🞏**partner | **🞏**parents | **🞏**alone |
| Do you exercise? | **🞏**yes | **🞏**no | How often? | /week |
| Do you have a good social support network? | **🞏**yes | **🞏**no |
| Do you have a religious/spiritual practice | **🞏**yes | **🞏**no |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Rate quality of sleep (10 best) | /10 | Do you struggle falling asleep? | **🞏**no**🞏**yes | How many hours do you sleep? |
| Rate your energy (10 best) | /10 | What time of day is your energy the best? |  |
| How is your body temperature compared to others | **🞏**Warmer | **🞏**Cooler | **🞏**Average |

**Reproductive**
**FEMALE Section**

|  |  |  |
| --- | --- | --- |
| Are you still menstruating? | **🞏** Yes | **🞏** NoIf no, what age did you stop? |
| Age at first menstruation? |  | Are cycles regular? | **🞏** Yes | **🞏**No |
| Cycle length | days | Do you bleed between periods? | **🞏** Yes  | **🞏**No |
| Describe the flow of your periods? | **🞏** Heavy | **🞏** Medium  | **🞏** Light |
| Do you experience premenstrual symptoms? | **🞏** Water retention | **🞏** Irritability | **🞏**Acne | **🞏** Food cravings | **🞏**Breast tenderness |
| **🞏**Depression | **🞏**Headaches | **🞏**Anger | **🞏**Bloating | **🞏**Mood swings |
| Number of Pregnancies |  | Number of live births | **🞏**Vaginal | **🞏**Caesarean Section |
| Any problems getting pregnant | **🞏** Yes | **🞏**No |
| Do you receive regular PAP smears? | **🞏** Yes | **🞏**No | Any abnormal? | **🞏**Yes | **🞏** No |
| Do you perform self breast exams? | **🞏** Yes | **🞏** No | Do you notice lumps in your breasts? | **🞏** Yes | **🞏** No |

**MALE Section**

|  |  |  |
| --- | --- | --- |
| How often do you get up at night to urinate? | **🞏** Yes | **🞏** No |
| Is this a recent change? | **🞏** Yes  | **🞏** No |
| Do you experience any problems achieving or maintaining an erection? | **🞏** Yes | **🞏** No |
| Do you have any sores on your penis? | **🞏** Yes | **🞏** No |
| Do you have any abnormal discharge? | **🞏** Yes | **🞏** No |
| Have you had your prostate examined?  | **🞏** Yes | **🞏** No |

**Digestion and Elimination**

|  |  |  |  |
| --- | --- | --- | --- |
| How often do you have a bowel movement? | **🞏** Formed | **🞏** Loose | **🞏** Require straining |
| Do you suffer from alternating constipation and diarrhea? | **🞏** Yes | **🞏** No | How often? |  |
| In the stool are the following present? | **🞏** blood | **🞏** mucous | **🞏**undigested food | **🞏** black colour |
| Do you suffer from the following?  | **🞏** bloating | **🞏** gas | **🞏**reflux |
| Do you avoid any foods because they trigger any other the above?Please list. |  |

**Occupational/Household**

|  |  |  |
| --- | --- | --- |
| Do you live in an older home? | **🞏** Yes | **🞏** No |
| Does your home tend to be damp or moldy? | **🞏** Yes | **🞏** No |
| Do you work in an office building  | **🞏** Yes  | **🞏** No  |
| Do the windows at your work open | **🞏** Yes | **🞏** No |
| Do you work in a factory or in presence of fumes of chemical?  | **🞏** Yes | **🞏** No |
| Do any of your hobbies involve toxic materials? | **🞏** Yes | **🞏** No |
| Are you currently exposed to second hand smoke? | **🞏** Yes | **🞏** No |
| Do you have any amalgam/silver fillings | **🞏** Yes | **🞏** No |

**Informed Consent to Treatment**

This consent form applies to patients of the Naturopathic Doctors (ND) at the Armstrong Clinic for Naturopathic Medicine. By consenting to treatment you are authorizing your ND to have access to your file and personal information. Please ask to review the privacy policy if you have questions about the use of your personal information by the Armstrong Clinic.

Even the gentlest therapies have their complication in certain physiological conditions such as pregnancy, lactation, in patients who are very young/very old, or in people who take multiple medications. Some therapies must be used with caution in certain diseases such as diabetes, lung, heart, liver, or kidney disease. It is very important that you are completely forthright in informing your ND of any disease process currently going on in your body, if you are on any prescription medication or OTC drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding please inform your ND immediately.

There are some slight health risks to treatment by Naturopathic Medicine. These include but are not limited to:

* Aggravation of pre-existing conditions and symptoms
* Allergic reactions to supplement or botanical prescriptions
* Pain, bruising or injury from venipuncture or acupuncture
* Fainting, organ puncture with acupuncture needles, accidental burning of the skin from the use of moxa.
* Muscle strains, sprains and disc injuries from spinal manipulation
* The potential for stroke or emboli is a concern in cervical spinal manipulation and proper pre-requisite tests will be done before such manipulations are performed to prevent such an outcome.

I understand that my ND keeps a record of services provided to me. This record will be kept confidential and will not be released to others unless so directed by myself or unless law requires it. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee. I understand that I must pay for all tests, in-office prescriptions and services when rendered, without refund after 14 days from purchase date. I understand that my identity will be protected and kept confidential.

I understand that my ND will answer my questions that I have to the best ability, in a manner, which I can comprehend. I understand that the results are not guaranteed. I do not expect my ND to be able to anticipate and explain all risks and complications. I will rely on my ND to exercise the best judgement in my best interests, based on the facts and findings then known. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for: (please list exceptions below)

I intend this consent form to cover the entire course of treatment presented for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time in written or verbal format.

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

Signature Print Name Date

Parent Signature if under 18 \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Primary Naturopathic Doctor: \_\_\_\_\_\_\_\_\_\_\_\_\_