Adult Intake

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION
(Please print clearly)

Name _____Date _____

Date of birth _____ (M/D/Y) Gender F M other_____

Occupation _____

Address:_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____ Cell:_____

Emergency contact: Name: _____

Phone number(s): (_____)_____ or_(_____)_____ Relation:_____

Referred by (Optional) _____

Have you ever consulted a naturopathic doctor, an acupuncturist, a nutritionist or counselor before? (Please circle) Yes No

Health Goals

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

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?
1	
2	
3	

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

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) _____3) _____

2) _____4) _____

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

1) _____3) _____

2) _____4) _____

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

1) _____3) _____

2) _____4) _____

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—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
Last time you had blood work done_____

Diet

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

1) _____3) _____

2) _____4) _____

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

_____

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

_____

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