NATURALLY GOOD HEALTH CLINIC
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Adult Naturopathic Intake Form

Welcome to Naturally Good Health Clinic. Your health questionnaire provides valuable information on the factors which influence your well being and contribute to the underlying causes of your health concerns. Please fill out the questions to the best of your ability and bring the form in with you to your first visit to our wellness centre.

GENERAL CONTACT INFORMATION

Name: _____
(*last name*) (*first name*) (*middle initial*)

Age: _____ **Gender:** □ Female □ Male **Date of Birth**: _____ /_____ /_____
DD MM YY

Address: _____
(*street address*) (*city*) (*province*) (*postal code*)

Telephone: Home _____ Work _____Cell _____

May we leave messages on your phone line? ____ Preference (circle all applicable): Home/ Work/ Cell

Email: _____

Occupation: _____**How did you hear about this clinic?** _____

Emergency Contact: _____
(*name*) (*relationship*) (*telephone*)

Primary physician _____ **Last physical exam** _____
(*name*) (*telephone*) (*month*) (*year*)

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are your most important health concerns that you are seeking treatment for or are currently being treated for? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Please list any past / current prescription medications, over the counter medications, vitamins, herbs, homeopathics or other supplements you have / are taking, the dosage and how effective you found these treatments:

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Approximately how many times have you been treated with antibiotics? _____

Are you hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmental? (e.g. pollen, dust, perfume) _____
_____

Please describe what type of reaction you experience with an allergy attack?
_____

_____

MEDICAL HISTORY

List all surgeries you have had:
_____year? _____ purpose? _____
_____year? _____ purpose? _____
_____year? _____ purpose? _____

Are there any traumatic events (surgeries, drug reactions, serious illness, accidents etc.) that you feel may have caused or contributed to your health problems?
_____

Please check all the childhood illnesses you have had:

Polio		Measles		Mumps		Rubella		Allergies	
Chicken pox		Whooping Cough		Scarlet Fever		Rheumatic Fever		Asthma	

Environmental Toxic Exposure

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, etc) while at work, home or travelling?	Y	N
Do you live near power lines or a refinery?	Y	N
Are your home and work environments well-ventilated?	Y	N
Are you exposed to significant tobacco smoke (work, home, etc.)?	Y	N
Are you frequently exposed to animals (work, pets, etc.)?	Y	N
Do you have mercury dental fillings?	Y	N
Do you have any surgical implants (medical, cosmetic)	Y	N
Do you have any body piercings?	Y	N
Have you ever had any organ transplants?	Y	N
Do you have a history of drug or alcohol abuse?	Y	N

Has there been an event or sickness that you have never fully recovered from? Please indicate below
_____

Please check all vaccinations you have had:

DPT (diphtheria, pertussis, tetanus)	□	Haemophilus influenza	□
Hepatitis A	□	Hepatitis B	□
MMR (measles, mumps, rubella)	□	Smallpox	□
Polio	□	Tetanus booster	□
Flu	□	Other	□

Have you experienced reactions to your vaccinations? Please explain:
_____
_____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Cravings: _____
Aversions: _____

Do you add **salt** to your food? □ Yes □ No

How many **cups / day** do you drink of the following?
Coffee ___ Black tea ____ Herbal tea ___ Do you add milk/cream? ____ Sugar? ____

Do you drink **pop**, how much? _____

How many glasses of **water** do you drink per day?
Tap____ Filtered_____ Distilled____ Reverse Osmosis _____Spring____

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

GENERAL

Weight ____lbs Weight one year ago ____lbs Max weight ____lbs Height _____

Blood Type _____

Rate your energy level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**

When during the day is your energy the best? _____ worst? _____

Rate your stress level between: **(low)** 1 2 3 4 5 6 7 8 9 10 **(high)**

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

Allergies	_____	Heart Disease	_____
Alzheimer's	_____	Kidney Disease	_____
Arthritis	_____	Mental illness	_____
Asthma	_____	Osteoporosis	_____
Autoimmune disease	_____	Parkinson's	_____
Cancer	_____	Seizure/Epilepsy	_____
Crohn's or colitis	_____	Stroke/Aneurysm	_____
Diabetes	_____	Thyroid condition	_____
Eczema	_____	Tuberculosis	_____

Other _____

REVIEW OF SYSTEMS

Please check the box if you are currently experiencing the symptom, or have in the past.

Mental/Emotional

	Past	Now		Past	Now
Mood swings	□	□	Anxiety or nervousness	□	□
Poor concentration	□	□	Memory Problems	□	□
Depression	□	□	Anger	□	□
Restlessness	□	□	Excessive worry	□	□

Endocrine

Thyroid disease	□	□	Heat or Cold Intolerance	□	□
Diabetes	□	□	Sugar Sensitivities	□	□
Fatigue	□	□	Weight loss/Weight gain	□	□

Lymphatic/Immune

Chronic Infections	□	□	Chronic swollen glands	□	□
Slow wound healing	□	□	Frequent colds	□	□

Skin

Rashes	□	□	Eczema, Hives	□	□
Acne, Boil	□	□	Itching	□	□
Dry, rough, scaly	□	□	Scars	□	□
Warts	□	□	Change in size/colour of mole	□	□
Cysts	□	□	Light/dark patches of skin	□	□
Colour change/ ridges/ pits on nails	□	□	Loss of hair	□	□

Head

Headaches	□	□	Migraines	□	□
Head Injury	□	□	Seizures/convulsions	□	□
Fainting	□	□			

Eyes

Poor eyesight (near or far)	□	□	Sensitivity to light	□	□
Double vision	□	□	Sudden change in vision	□	□

Ears

Earaches	□	□	Impaired hearing	□	□
Dizziness	□	□	Ringing in ears	□	□
Sensitivity to noise	□	□	Discharge from ears	□	□

Nose and Sinuses

Nosebleeds	□	□	Seasonal Hay fever	□	□
Sinus problems	□	□	Loss of smell	□	□

Mouth and Throat

Frequent sore throat	□	□	Sore tongue/lips	□	□
Tonsils removed	□	□	Loss of taste	□	□
Persistent hoarseness	□	□	Difficulty swallowing	□	□
Bleeding gums	□	□	Loss of teeth	□	□
Recurrent sores	□	□	Mercury amalgams	□	□

Respiratory

	Past	Now		Past	Now
Chronic Cough	□	□	Wheezing	□	□
Asthma	□	□	Bronchitis	□	□
Emphysema	□	□	Chronic Phlegm	□	□
Shortness of breath	□	□	Chest congestion	□	□
Chest pain when breathing	□	□	Difficulty breathing at night	□	□

Cardiovascular

Heart disease	□	□	High/Low Blood Pressure	□	□
Palpitations	□	□	Arrhythmia	□	□
High Cholesterol	□	□	Heart murmur	□	□
Chest pain when walking	□	□	Chest pain when sitting/ lying	□	□
Numbness/tingling in arm	□	□	Leg vein problems	□	□

Gastrointestinal

Heartburn	□	□	Belching or Passing Gas	□	□
Change in thirst	□	□	Change in Appetite	□	□
Constipation	□	□	Diarrhea	□	□
Abdominal bloating	□	□	Frequent or severe nausea	□	□
Frequent vomiting	□	□	Vomiting blood	□	□
Stomach/abdominal pain	□	□	Indigestion	□	□
Irritable if miss a meal	□	□	Bad breath	□	□
Distress from fatty foods	□	□	Gallbladder attack	□	□
Liver problems	□	□	Jaundice	□	□
Hemorrhoids	□	□	Blood in stool	□	□
Black stool	□	□	Undigested food in stool	□	□

How often do you have a bowel movement? _____ Have you ever had parasites? _____

Urinary

Increased frequency	□	□	Frequency at night	□	□
Chronic Infections	□	□	Incontinence	□	□
Painful urination	□	□	Difficulty passing urine	□	□
General water retention	□	□	Back pain in kidney area	□	□

Musculoskeletal / Neurological

Pain/stiffness in joints	□	□	Tendonitis/bursitis	□	□
Muscle spasms/ cramps	□	□	Arthritis	□	□
Sore/ stiff muscles	□	□	Herniated/degenerated discs	□	□
Loss of balance	□	□	Loss of sensation in hands /feet	□	□
Loss of strength	□	□	Loss of coordination	□	□
Loss of muscle tone	□	□	Exhaustion on slightest effort	□	□

WOMEN'S HEALTH

Age of your first menstrual period _____ When was your last menstrual period? _____
How many days do you bleed? _____How long is your typical menstrual cycle? _____

Do you experience?

Heavy flow	□ Yes	□ No	Light flow	□ Yes	□ No
Clotting	□ Yes	□ No	Bleeding between periods	□ Yes	□ No

Do you suffer from pre-menstrual symptoms? □Yes □ No
If yes, which ones?

- □ Pain or cramping
- □ Bloating and/or water retention.
- □ Breast tenderness
- □ Mood Swings
- □ Headaches
- □ Cravings

Are you pregnant? □Yes □ No
Number of pregnancies _____
Number of miscarriages _____
Have you ever had a hysterectomy? □ Yes □ No
Have you ever used birth control? What type? _____

Please indicate if any of the following applies to you

□ Vaginal Discharge
□ Pain during intercourse
□ Vaginal Itching
□ Vaginal Odour
□ Absent menstruation
□ Abnormal pap tests
□ Low libido
□ Vaginal dryness
□ Pelvic pain
□ Genital sores

When was your last pap test? _____

Breast Health

Do you perform monthly self breast exams? □ Yes □ No
When was your last breast exam? _____
Do you have regular mammograms? □ Yes □ No
Do you have regular breast thermography? □ Yes □ No

Please indicate if any of the following applies to you

□ Breast lumps
□ Nipple discharge
□ Breast pain

MEN'S HEALTH

Please indicate if any of the following applies to you

□ Hernia
□ Low sex drive
□ Discharge or sores
□ Impotence
□ Testicular mass and or pain
□ Prostate condition. Year of last prostate exam? ___

LIFESTYLE

Do you exercise?	□Y	□N	How often? _____		
Do you fall asleep easily?	□Y	□N	Average 6-8 hrs of sleep?	□Y	□N
Sleep soundly?	□Y	□N	Awake rested?	□Y	□N
Do you smoke tobacco?	□Y	□N	Do you chew tobacco?	□Y	□N
Do you use recreational drugs?	□Y	□N	Do you drink alcohol?	□Y	□N
Do you eat out often?	□Y	□N	How often? _____		
Do you enjoy your work?	□Y	□N	Explain_____		
Do you take vacations?	□Y	□N	How often?_____		
Do you watch TV?	□Y	□N	How many hours per day?_____ week?_____		

What are your hobbies? _____

What are your current health goals?_____

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

_____

_____

Thank you for taking the time to fill out these forms.