Adult Intake Form

Full Name

First Name Last Name

Date

Month Day Year

Address

Street Address

Street Address Line 2

City State / Province

Postal / Zip Code Country

E-mail

example@example.com

Home Phone Number

Area Code Phone Number

Work Phone Number

Area Code Phone Number

May we leave messages relating to your visits?

Yes

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No

Emergency Contact

First Name Last Name

Phone Number

Area Code Phone Number

Relation

How did you hear about our Clinic?

Referal
Advertisement
Other

Other health care providers you are seeing (Name, Address, Phone#)

Does your insurance provider cover Naturopathic Medicine?

Yes
No
Unsure

Medical History

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

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Are you currently pregnant?

Yes

No

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

Do you have any allergies (medicine, animals, chemicals, food, etc.)?

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

Do you regularly get screening tests done by a health care professional?

Yes

No

Which ones?

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- Blood tests
- Bone density scan (DEXA)
- Mammogram
- Pap
- Digital Rectal Exam (prostate exam)
- Fecal occult blood
- Other

Do you frequently use any of the following?

- Laxatives
- Pain Relievers
- Antacids
- Appetite Suppressants
- Antidepressants
- Antibiotics
- Birth control pills/implants/injections/patch
- Cholesterol-lowering medication
- Ulcer medication
- Sleeping medication

Alcohol-how much/day or week

Tobacco-form and amount/day

Caffeine-form and amount/day

Recreational drugs-what how often

Please indicate what immunizations you have had

- DPT (diptheria, pertussis, tetanus)
- Tetanus booster
- MMR (measles, mumps, rubella)
- Haemophilus influenza B
- "Flu"
- Polio

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Hepatitis A
Hepatitis B
Smallpox
HPV
Varicella (Chicken Pox/Shingles)

Please indicate if any caused adverse reactions:

Do you have any dietary restrictions?

Family History

Please indicate any family history of (Allergies, Asthma, Heart Disease, High Blood Pressure, Cancer, Depression, Mental Illness, Drug Abuse/Alcoholism, Kidney Disease, Other)

Environment

Occupation

Hobbies

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Do you exercise regularly?

Yes

No

What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)

Yes

No

Are you frequently exposed to animals?

Yes

No

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

How would you describe the emotional climate of your home?

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

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

Naturopathic Care

Have you seen a Naturopathic Doctor before?

Yes

No

What are your health related goals?

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