New Patient Intake Form

Bring this form to your first appointment

Thank you for your time, thoughtfulness and honesty in completing this health overview. Successful health care is only possible when the physician has a complete understanding of not only the physical but also the mental and emotional picture of you the patient.

Full Name ____________________________________

Address ______________________________ City________________ P/C__________

Telephone: Home (___)__________ Work_(___)__________

Email______________________________________

Date of Birth (D/M/Y) __________________Age ___________ Gender Male / Female

Occupation ____

Number of hours worked per week _______

Name of Medical Doctor____

Telephone ( )________________

Are you currently under his/her care? Yes / No

If yes, for what condition(s)?____

Date of last physical____________

How or by whom were you referred to this clinic?_________________________

Have you been treated by a Naturopathic Doctor before? Yes No

If yes, by whom?__________________________ When?__________________

In case of Emergency:
Contact __________________ Relation: __________________ Telephone _________

May messages pertaining to clinic visits be left (please circle):

Home machine With family members At work Never leave messages

Current Health

What are your primary health concerns? List as many as you can, in the order of their importance to you. (attach a separate sheet if necessary)

1) ____

2) ____

3) ____

4) ____

5) ____

Are you aware of having allergies or sensitivities to any of the following? If so, describe your specific sensitivity and reaction to each one.

Drugs____

Foods____

Chemicals____

Animals____

Other____

Please list, all **current** prescription medications, over-the-counter medications, and all vitamins/supplements/herbs you take regularly. What are there effectiveness?
Please bring each of these with you to your first visit.

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Do you regularly get screening tests done by a health care professional? Yes / No
Which ones? (Please circle)

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

Are you exposed to tobacco smoke or other types of inhalants? Y / N

Please circle all that apply in your home:

Pet
Mostly Carpet
New home
Gas heating

Do you frequently use any of the following? (Please circle)

Laxatives

Pain Relievers

Antacids

Appetite Suppressants

Antidepressants

Antibiotics

Birth control
(pills/implants/injections/patch)

Cholesterol-lowering medication

Ulcer medication

Sleeping medication

- ❑ Alcohol → Type and amount per week? __________________________
- ❑ Tobacco → Form and amount per day? ___________________________
- ❑ Caffeine → Form and amount per day? ___________________________
- ❑ Recreational Drugs → Form and frequency? _______________________

Females only:
Are you currently pregnant? Yes / No

General Information

Height _________________ Weight _______________

Weight 1 yr ago __________ Maximum weight ___________ When __________

What time of day is your energy and alertness best? _______ Worst? ________

Primary interests and hobbies _______________________________________

Primary form of exercise, if any _____________________________________
How often?____

Medical History

Which of the following conditions do you currently experience or have had in the past? (please circle)

Abuse	Heart Disease	Prostatitis
Alcoholism	Hemorrhoids	Rheumatic Fever
Asthma	Hepatitis	Scarlet Fever
Cancer	Herpes	Strep Throat
Chicken Pox	Influenza	Sinusitis
Cold Sores	HIV	Stroke
Depression	Kidney Disease	Syphilis
Diabetes	Malaria	Thyroid Problems
Emphysema	German Measles	Tuberculosis
Endometriosis	Mononucleosis	Typhoid Fever
Epilepsy	Mumps	Warts
Gall Stones	Parasites	Whooping Cough
Gonorrhea	PID	Worms
Gout	Pneumonia	
Hay Fever	Psoriasis	

Please list any serious illnesses, injuries, hospitalizations, surgeries and conditions along with approximate dates. **Include dental work (even regular fillings).**

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Please list all past medications taken in the past 12 months

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Please indicate which immunizations you have had (Please circle)

DPT (diptheria, pertussis, tetanus)
Tetanus booster (Date?_______)
MMR (measles, mumps, rubella)

Smallpox
Chicken Pox
Hepatitis B
Hepatitis A
Polio

Haemophilus
Flu vaccine (Date?_______)
Other

Have you ever had an adverse reaction to an immunization? Y / N
If yes, please describe____

Please list past places of travel in the last 12 months

____

Family History

Do you have a family history of any of the following diseases or conditions? When answering, include your parents, brother/sisters, and grandparents, if known.
Check all that apply.

	Father	Mother	Child	Other (please specify)
Age (if living)				
Health (good,poor)				
Age at death				
Cause of death				
Cancer				
Diabetes				
Epilepsy				
Heart Disease				
High Blood Pressure				
Drug Abuse/Alcoholism				
Depression				
Mental Illness				
Asthma / Eczema				
Allergies				
Kidney Disease				
Autoimmune (MS, Lupus, RA)				
Psoriasis				

Please list other significant family medical history not listed above:

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Nutrition

Do you have any dietary restrictions (e.g. vegetarian, religious, ethical etc.)? Please describe

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Indicate which of the following are true (please circle).

Eat 3 meals or more per day

Go on diets more than once yearly

Drink tea / coffee

Drink soft drinks

Use products with artificial sweeteners

Add sugar/salt to food

Eat out more than twice a week

Describe a typical day's diet.

Breakfast____

Snack____

Lunch____

Snack____

Dinner____

Snack____

Amount of water ____

Lifestyle

Please indicate which of the following are true (please check).

- ❑ Get 6-8 hours of sleep per night
- ❑ Sleep well
- ❑ Awake feeling rested
- ❑ In a supportive relationship
- ❑ History of abuse
- ❑ Suffered major life trauma
- ❑ Enjoy your work
- ❑ Take vacations How often?_____________
- ❑ Spend time outside
- ❑ Watch TV Hours daily?_____________
- ❑ Read Hours daily?_____________

Using the scales below, please rate yourself in terms of satisfaction and dissatisfaction in areas of your life. Number 1 means you are very dissatisfied or stressed. Number 10 means you are very satisfied or comfortable.

	0	1	2	3	4	5	6	7	8	9	10
Friends & Family											
Physical Environment											
Health											
Career											
Relationships/Romance											
Recreation											
Money											
Personal Growth / Spirituality											

Do you have any other concerns that have not been covered?

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______________________________ ________________

Signature Date

Thank you for your time and effort.