

Naturopathic Patient Intake Form

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Date: _____

Name: _____ Age: _____ Date of Birth: _____

Address: _____ City: _____ Postal Code: _____

Phone: Home: _____ Work: _____ Height: _____ Weight: _____

Occupation: _____ How did you hear about the clinic? _____

E-Mail Address: _____ May we contact you this way? _____

In Case of Emergency: _____ Phone: _____

Doctor: _____ Phone: _____

What are your main concerns?: _____

What may have played a role in your health concerns?: _____

What have you tried to improve your condition(s)?: _____

Is your health currently getting better, worse or staying the same? _____

What makes it better? _____

What makes it worse? _____

Have you consulted a Naturopathic Doctor before? Y N Who? _____

Have you consulted a Chiropractic Doctor before? Y N Who? _____

Have you consulted a Massage Therapist before? Y N Who? _____

Are you currently working with any other health professionals? Y N Who? _____

Please list the three most stressful events in your life (past or present): _____

Rate your current stress level from 1-10 (10 being the worst): _____

Please list below any allergies/ sensitivities and the symptoms they cause:

Drugs: _____

Foods: _____

Environment: _____

Other: _____

Family History: Please circle if anyone in your family has suffered from any of the following conditions:

Heart Disease Alzheimers Diabetes Thyroid Problems Asthma
Tuberculosis Alcoholism Drug Abuse Rheumatoid Arthritis
Allergies High Blood Pressure Eczema Osteoarthritis
Celiac Disease Kidney Disease Mental Illness Depression MS
Psoriasis Learning Disability Cancer (types: _____)
Does cancer run in your family? Yes No
Other: _____

Personal Medical history:

Please circle your blood type: A B O AB I don't know

List any hospitalizations, surgeries, and/or procedures you've had (date, and why?)

List any past trauma or accidents with the date: _____

Childhood History:

Were you breastfed? Y N For how long? _____

Were you bottle-fed? Y N For how long? _____

Are you immunized? Y N If yes, did you have any reaction? _____

Was your birth process natural? Y N Were there any complications? _____

Which childhood illnesses did you have? Please circle

Polio Chicken Pox German measles Ear Infections Colic
Mumps Rheumatic Fever Whooping Cough Worms
Red measles Eczema/rashes Allergies Bronchitis/Pneumonia
Other? _____

Have you ever suspected or been diagnosed with parasites? Y N

Have you ever had Mono (Epstein Barr Syndrome)? Y N

Have you ever been diagnosed with any of the following?

Heart Trouble Y N Diabetes Y N AIDS Y N Circulation Problems Y N

Thyroid Disease Y N Cancer Y N Arthritis Y N Autoimmune Disease Y N

What do you feel is your weakest organ system and why? _____

How many times a year do you get sick? _____ With what? _____

How long do they last? _____

Do you wear a Medical Alert bracelet or tag? Y N For what? _____

Do you drink 6-8 glasses of water per day Y N How many do you drink? _____

Do you exercise regularly? Y N What type/frequency? _____

Do you smoke? Y N When did you start and how much do you smoke? _____

Do you drink alcohol? Y N Frequency? _____

Do you take recreational drugs? Y N What type and frequency? _____

Are you on a special diet? Y N Explain: _____

Do you have any cravings? Y N Specify: _____

How many hours of sleep do you get? _____ Is it restful? _____

Do you wake in the night? _____ If so, is it at a particular time? _____

How many children do you have? _____ Do they live with you? Y N

Marital Status (circle all that currently apply):

single married divorced separated widowed

Is your job associated with potentially harmful chemicals (i.e Pesticides, Solvents, Radioactivity) or health and/or life threatening activities (i.e. mining, firefighting)?

Specify: _____

What time of day do you have the most energy? _____

What time of day do you have the least energy? _____

What do you do to relax? _____

How often do you take the time for relaxation? _____

Is there anything else that you feel is important that hasn't been addressed? _____

