Naturopathic Patient Intake Form

Kamerin Matheson, B.A.H, ND. **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? _____
_____
_____