(Naturopathic Intake forms)

PERSONAL INFORMATION

Name ____________________________________ Date of First Visit _____________________

Blood type____________________ # of Children_______________________

Address ____

City ____________________________ Province ____________ Postal Code _____________

Telephone # (home) _________________________ (work) ______________________________

E-mail _____________________________________ Relationship Status ___________________

Age _____ Date of Birth (M/D/Y) __________________ Gender: female ____ male ____

Occupation ___________________Hours per week ______ Employer_____________________

Has any other family member already been a patient at the clinic? _______________________

Next of Kin or other to reach in an emergency ____

Relationship _____________________ Phone ____

HEALTH OVERVIEW

Name of current general practitioner (MD) ____

GP's contact information ____

When was your last visit to your GP? ____

What was the reason? ____

Are you seeing a medical specialist? Y N

If yes, for what reason? ____

Name of medical specialist ____

Do you have any known contagious diseases at this time? Y N If yes, what? ________________

What is the main reason for your visit today? ____

____

What are your most important health problems? List as many as you can in order of importance.

1. ____

2. ____

3. ____

4. ____

5. ____

6. ____

How did you hear about our clinic? ____

Cancellation Policy

I understand that I am responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Consent

I hereby consent to receive treatment by the practitioners of Complement Your Health Naturopathic Clinic. I understand that this consent is voluntary and may be revoked by me at any time. I understand the fee structure, and accept responsibility for prompt payment.

Signature: ___________________________________ today's date: ______________

(Parent or Guardian if a minor)

HEALTH HISTORY QUESTIONNAIRE

FAMILY HISTORY

Do you have a family history of any of the following (please circle)?

Cancer	Diabetes	Heart Disease
Kidney Disease	Epilepsy	High Blood Pressure
Tuberculosis	Stroke	High Cholesterol
Asthma / Hayfever / Hives	Arthritis	Anemia

Other relevant family history: ____

What is your ethnic heritage? ____

CHILDHOOD ILLNESSES

Scarlet Fever	Diphtheria	Rheumatic Fever
Mumps	Measles	German Measles

IMMUNIZATIONS

	Polio		Pertussis
	Tetanus shot: when? ______________		Diphtheria
	Measles / Mumps / Rubella		Travel Related:

HOSPITALIZATIONS, SURGERIES, IMAGING

What hospitalizations or surgeries, X-rays, CAT scans, EEG, EKG's have you had?

__________________________ Year: _______ __________________________ year: _________

__________________________ Year: _______ __________________________ year: _________

__________________________ Year: _______ __________________________ year: _________

ALLERGIES / SENSITIVITIES

Are you hypersensitive or allergic to...?

Any drugs? ____

Any foods? ____

Any environmentals or chemicals? ____

CURRENT MEDICATIONS

Do you take or use?

Laxatives	Y N	Pain relievers	Y N	Antacids	Y N
Cortisone	Y N	Appetite suppressants	Y N	Antibiotics	Y N
Tranquilizers	Y N	Thyroid medication	Y N	Sleeping pills	Y N

Please list any prescription medications, over the counter medications, vitamins or other supplements you are taking?

1) ______________________ 5) ______________________

2) ______________________ 6) ______________________

3) ______________________ 7) ______________________

4) ______________________ 8) ______________________

GENERAL

Height ____________ **Weight** _________ **lbs.** **Weight 1 year ago** ________**lbs.**

Max Weight _ Ibs. When _________ **Min Adult Weight** ______ **Ibs** **When** ____________

When during the day is your energy the best? ____________ **Worst?** ____________________

REVIEW OF SYSTEMS

Check any of the following conditions you currently have (C), or have had in the past (P).
Please also check if you feel any of the following are a significant part of your medical history.

LIFESTYLE

	Alcohol		History of Smoking	Current Past
	Marijuana		- How many packs per day?	
	Drugs		- How many years?	
	Treated for drug dependence		Occupational Hazards	
	Stress		Any major traumas	

MENTAL/EMOTIONAL

	Treated for emotional problems		Depression
	Mood swings		Anxiety
	Considered/attempted suicide		Nervousness
	Poor Concentration		Memory problems

ENDOCRINE

	Hypothyroid		Heat or cold intolerance
	Hypoglycemia		Diabetes
	Excessive thirst		Excessive hunger
	Fatigue		Seasonal depression

IMMUNE

	Chronic fatigue syndrome		Current infection: __________________
	Chronically swollen glands		Chronic infections
	Reactions to vaccines		Slow wound healing

NEUROLOGIC

	Seizures		Heat or cold intolerance
	Muscle weakness		Numbness of extremities
	Tremor		Tingling of extremities
	Vertigo or dizziness		Loss of memory

SKIN

	Rashes		Eczema or Hives
	Acne or Boils		Itching
	Color change		Perpetual hair loss
	Lumps		Night sweats

HEAD

	Headaches		Head injury
	Migraines		Jaw/TMJ roblems

EYES

	Spots in eyes		Cataracts
	Impaired vision		Glasses or contacts
	Blurriness		Eye strain or pain
	Color blindness		Tearing or dryness
	Double vision		Glaucoma

EARS

	Impaired hearing		Ringing in the ears/Tinnitus
	Earaches		Dizziness

NOSE AND SINUSES

	Frequent colds		Nose bleeds
	Stuffiness or post-nasal drip		Hayfever
	Sinus problems		Loss of smell

MOUTH AND THROAT

	Frequent sore throat		Copious saliva
	Teeth grinding		Sore tongue/lips
	Gum problems		Hoarseness
	Dental cavities		Jaw clicks

NECK

	Lumps		Swollen glands
	Goiter		Pain or stiffness

RESPIRATORY

	Cough		Sputum
	Spitting up blood		Wheezing
	Asthma		Bronchitis
	Pneumonia		Pleurisy
	Emphysema		Difficulty breathing
	Pain on breathing		Shortness of breath
	Shortness of breath at night		Shortness of breath lying down

CARDIOVASCULAR

	Heart disease		Angina
	High/Low blood pressure		Murmurs
	Blood clots		Fainting
	Phlebitis		Palpitations/Fluttering
	Rheumatic fever		Chest pain
	Swelling in ankles		High Cholesterol

GASTROINTESTINAL

	Trouble swallowing		Constipation
	Reflux		Diarrhea
	Heartburn		Blood with stool
	Vomiting blood		Change in bowel movements
	Nausea		Abdominal pain or cramps
	Change in appetite		Ulcer
	Vomiting		Black stools
	Belching		Colon Polyps
	Gas		Jaundice
	Hemorrhoids		Liver disease

URINARY

	Pain on urination		Frequency at night
	Increased Frequency		Inability to hold urine (urgency)
	Frequent infections		Kidney stones

MUSCULOSKELETAL

	Joint pain or stiffness		Arthritis
	Broken bones		Weakness
	Muscle spasms or cramps		Sciatica

BLOOD/PERIPHERAL VASCULAR

	Easy bleeding or bruising		Anemia
	Deep leg pain		Cold hands/feet
	Varicose veins		Thrombophlebitis

FEMALE REPRODUCTION/BREASTS

Age of first menses ___________ Length of cycle ________________________________

Duration of Menses _______________ Age of last menses (if menopausal) ______________

Date of last annual exam/ PAP (M/D/Y) ____

	Irregular cycles		Abnormal PAP
	Bleeding between cycles		Cervical Dysplasia
	Cramping with menses		Endometriosis
	Premenstrual Syndrome		Ovarian cysts
	Clotting		Uterine Fibroids
	Heavy or excessive flow		Sexually Active
	Vaginal Discharge		Painful Intercourse
	Menopausal Symptoms		Sexual difficulties
	Breast lumps		Sexually Transmitted Disease
	Breast pain/tenderness		Birth Control: type _________________
	Nipple discharge		Difficulty conceiving

Number of pregnancies ______________________ **Number of live births** ______________________

Number of miscarriages ______________________ **Number of abortions** ______________________

Do you do breast self exam? ___________________ **Have you had a hysterectomy?** _________________

MALE REPRODUCTION

	Hernias
	Testicular masses
	Testicular pain
	Prostate disease
	Sexually Active

	Sexually Transmitted Disease
	Discharge or sores
	Impotence
	Premature ejaculation
	Birth Control: Type _________________