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Female Naturopathic Intake Form

GENERAL CONTACT INFORMATION

Name: _____
(*last name*) (*first name*) (*middle initial*)

Age: ____ **Gender:** □ Female □ Male **Date of Birth**: _____ /_____ /_____
DD MM YY

Address: _____
(*street address*) (*city*) (*province*) (*postal code*)

Telephone: Home _____Work _____ ____Cell _____

May we leave messages on your phone line? ____ Preference (circle all applicable): Home/ Work/ Cell

Email: _____

Occupation: _____ Employer : _____

How did you hear about this clinic? _____

Who referred you to the Center for Healthy Living? _____

Emergency Contact: _____
(*name*) (*relationship*) (*telephone*)

Primary physician _____ **Last physical exam** _____
(*name*) (*telephone*) (*month*) (*year*)
Specialist (s) : _____ **Last bloodwork/ labs** _____
(*name*) (*telephone*) (*month*) (*year*)

Please list any additional health care providers with their designation and contact information:

_____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

What are your main health concerns? List as many as you can in order of importance.

1) _____

2) _____

3) _____

4) _____

5) _____

Please list any past / current prescription medications, over the counter medications, vitamins, herbs, homeopathics or other supplements you are taking, the dosage and how effective you have found these treatments:

1) _____

2) _____

3) _____

4) _____

5) _____

Approximately how many times in the last 5 years have you been treated with antibiotics? _____

Are you hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmental? (e.g. pollen, dust, perfume) _____

_____

Have you had any specific allergy testing? If yes, please explain: _____

MEDICAL HISTORY

List all surgeries you have had:

_____year? _____ purpose? _____
_____year? _____ purpose? _____
_____year? _____ purpose? _____

Are there any traumatic events (surgeries, drug reactions, serious illness, accidents etc.) that you feel may have caused or contributed to your health problems?

_____
_____
_____
_____
_____
_____

Environmental Toxic Exposure

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium etc) while at work, home or travelling?	Y	N
Do you live near power lines or a refinery?	Y	N
Is your home and work environment well-ventilated?	Y	N
Do you smoke, or are you exposed to 2nd hand smoke?	Y	N
Do you have mercury dental fillings?	Y	N
Do you have any surgical implants (medical, cosmetic)?	Y	N
Do you have any body piercings?	Y	N

Has there been an event or sickness that you have never fully recovered from? Please indicate below

_____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
Beverages: _____
Cravings: _____
Aversions: _____

Do you add **salt** to your food? □ Yes □ No

How many **cups / day** do you drink of the following?
Pop ___ Fruit juice ____ Tea ___ Cow's Milk____Alcohol_____Coffee_____

How many glasses of **water** do you drink per day?
Tap____ Filtered_____ Distilled____ Reverse Osmosis _____Spring____

What temperature of liquid do you prefer to drink? (circle) hot cold room temp.

Do you have any dietary restrictions (religious, vegetarian, vegan etc.)?
_____

Are you satisfied with your diet the way that it is now? Why or why not?
_____
_____

GENERAL

Current Weight _____ Height _____ Blood Type _____
Ideal Weight _____ As an adult what has your maximum _____ and minimum _____ weight been?

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (grandparents, parents, siblings).

Allergies	_____	Eczema	_____
Anemia	_____	Heart Disease	_____
Asthma	_____	Juvenile Arthritis	_____
Autoimmune disease	_____	Kidney Disease	_____
Birth defects	_____	Mental illness	_____
Bleeding disorder	_____	Seizure/Epilepsy	_____
Cancer	_____	Stroke/Aneurysm	_____
Crohn's or colitis	_____	Thyroid condition	_____
Diabetes	_____	Tuberculosis	_____

Other _____

SYMPTOM CHECKLIST

Please take a moment to indicate the following symptoms or conditions you may have experienced either in the past, or presently.

Symptom Checklist	**Past**	**Now**
Appetite change	□	□
Bad breath	□	□
Blood in urine	□	□
Blood in stool	□	□
Black stools	□	□
Burning urination	□	□
Chronic bleeding nose	□	□
Chronic bruising	□	□
Chronic runny nose	□	□
Gas / cramping	□	□
Constipation	□	□
Cough	□	□
Fainting	□	□
Weight loss	□	□
Weight gain	□	□
Diarrhea	□	□
Shortness of breath	□	□
Difficulty concentrating	□	□
Difficulty sleeping	□	□
Dizziness	□	□
Easy bruising	□	□
Eczema / Hives	□	□
Fatigue	□	□
Hair loss	□	□
Headaches	□	□
Hearing loss	□	□
Indigestion	□	□
Insomnia	□	□
Nervousness	□	□
Nights sweats	□	□
Sore throat	□	□
Stomach aches	□	□
Irritability	□	□
Urinary frequency	□	□
Visual disturbances	□	□
Vomiting	□	□
Wheezing	□	□
Other: _____		

Conditions	**Past**	**Now**
Acute epiglottitis	□	□
ADHD / ADD	□	□
Depression	□	□
Anxiety	□	□
Allergies	□	□
Anemia	□	□
Appendicitis	□	□
Asthma	□	□
Autism	□	□
Bronchitis	□	□
Cancer	□	□
Alcoholism	□	□
Arthritis	□	□
Cold sores	□	□
Hemorrhoids	□	□
Congenital diseases	□	□
Diabetes	□	□
Frequent colds	□	□
Fevers	□	□
Hypoglycemia	□	□
Skin rashes	□	□
Measles	□	□
Meningitis	□	□
Mononucleosis	□	□
Mumps	□	□
Pneumonia	□	□
Gallbladder disease	□	□
Rheumatic fever	□	□
Thyroid problems	□	□
Heart disease	□	□
Seizures	□	□
Sinusitis	□	□
Thrush	□	□
Tonsillitis / Strep throat	□	□
Urinary tract infections	□	□
Whooping cough	□	□
Miscarriage	□	□
Other: _____		

MENSTRUAL HISTORY

Age at first menses: _____ Length of cycle in days: _____
Are you currently taking prescription birth control? □ yes □ no
Is yes, what kind _____
Have you ever taken prescription birth control? □ yes □ no
If yes, what kind(s)? _____
For how long? _____

Do you cycle each month? □ yes □ no
If no, has it been longer than one year since your last cycle? □ yes □ no
Are you cycles regularly spaced apart? □ yes □ no
Do you experience any of the following (please circle)?

Breast tenderness	Mood Swings	Anxiety
Irritability	Fatigue	Cravings
Acne	Flu symptoms	Spotting
Bloating	Depression	Cramping
Nausea/Vomiting	Vaginal Dryness	Hot Flashes
Low Libido	Vaginal Discharge	Infertility

Have you ever had a vaginal yeast infection? □ yes □ no
If yes, are these a chronic issue? □ yes □ no
Have you ever had a urinary tract infection? □ yes □ no
If yes, are these a chronic issue? □ yes □ no
Have you ever been diagnosed with an STD? □ yes □ no

# of pregnancies _____ vaginal birth or c-section?
# of miscarriages/ abortions _____
Any complications related to pregnancy/ childbirth?
_____
_____
_____

LIFESTYLE PATTERNS

What time do you go to bed?_____ Wake ?_____
Do you have trouble falling asleep? _____
Do you sleep through the night?_____
Do you wake up feeling refreshed?_____
Do you have any recurring dreams or nightmares? _____
_____
What is your energy like during the day?_____
What is your current stress level? _____
Can you identify significant stressful periods in your life that you believe have impacted your health?
_____
_____
_____

Do you exercise? Yes No How often?_____ Type _____
What do you do to relax?_____
What are your hobbies / interests? _____

What are your health goals?
_____
_____
_____

Thank you for taking the time to fill out these forms.