RIVIERE
NATUROPATHIC HEALTH CLINIC
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# Adult Intake Form

We are aware of the time it takes to fill out such a lengthy intake form. However, your co-operation in completing it is essential to providing the highest standard of care. All information is confidential. PLEASE PRINT.

## REGISTRATION INFORMATION

Name: _____ Today's Date: _____
(First) (Middle) (Last) mm dd yy

Date of Birth: ____/____/____ Age: _____ Gender: _____
mm dd yy

Home Address: _____ City: _____

Postal Code: _____ Home Telephone ( )_____ Work: ( )_____

May we leave messages on your home phone relating to our visits? Y N

Email Address: _____

Emergency contact: _____ Relation: _____

Phone: ( )_____

How did you find out about our clinic?
- ✓referral – Whom may we thank? _____
- ✓website
- ✓yellow pages
- ✓health food store
- ✓other _____

Family Physician: _____ Phone: ( )_____

Other Health Care Provider(s): _____ Phone: ( )_____

_____ Phone: ( )_____

## CHIEF HEALTH CONCERNS

What are your health concerns? (List in order of importance to you):

1. _____
2. _____
3. _____
4. _____
5. _____

List any other concerns you may want to discuss:

_____

_____

_____

If you are female, are you currently pregnant? Y N

## MEDICAL HISTORY

How would you describe your general state of health? (circle) Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations along with approximate dates.

_____

_____

_____

Do you have any allergies (medicines, environmental, etc.)?

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

_____

_____

_____

Please list all past prescription medications.

_____

_____

_____

How many times have you been treated with antibiotics? _____

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

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol – how much/day or week _____

Caffeine – form and amount/day _____

Recreational drugs – what and how often _____

Please indicate what immunizations you have had (✓):

| | | |
|---|---|---|
| _____ DPT (diphtheria, pertussis, tetanus) | _____ Haemophilus influenza B | _____ Hepatitis A |
| _____ Tetanus booster | _____ "Flu" | _____ Hepatitis B |
| _____ MMR (measles, mumps, rubella) | _____ Polio | _____ Smallpox |

Did you experience any adverse reactions to past immunizations?

_____

_____

Do you get regular screening tests done by another doctor (Pap, blood tests, etc.)? Y N

## FAMILY HEALTH HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

| | Who? | | Who? |
|---|---|---|---|
| Allergies | | High blood pressure | |
| Alcoholism | | Kidney disease | |
| Asthma | | Mental illness | |
| Arthritis | | Mononucleosis | |
| Cancer (type) | | Multiple Sclerosis | |
| Chronic Bronchitis | | Osteoporosis | |
| Diabetes | | Rheumatic Fever | |
| Depression | | Skin diseases | |
| Drug abuse | | Strep throat | |
| Emphysema | | Stroke | |
| Hepatitis | | Tuberculosis | |
| Heart disease | | Other | |

☐ I don't know my family medical history

## GENERAL HISTORY

Check the symptoms/conditions which apply to you:

### ✓Generals

_____ noticeable weight loss
_____ noticeable weight gain
_____ fever
_____ fatigue
_____ weakness

### ✓Skin

_____ rashes
_____ changes in hair/nails
_____ eczema
_____ boils
_____ colour change
_____ itching
_____ hives
_____ moles
_____ lumps
_____ dryness
_____ psoriasis

### ✓Head

_____ head injury
_____ hair loss
_____ headaches
_____ dandruff

### ✓Eyes

_____ redness
_____ specks
_____ spots
_____ excessive tearing
_____ pain
_____ flashing lights
_____ double vision
_____ cataracts
_____ discharge
_____ glaucoma
_____ crossed eyes
_____ bothered by the sun
_____ blurred vision
_____ blind spot

Do you wear glasses/contacts? _____ Date of last eye exam? _____

✓**Ears**

_____ infection
_____ discharge
_____ ringing in ears (tinnitus)
_____ earaches
_____ vertigo
_____ hearing loss

Do you use hearing aids? _____ Date of last hearing test? _____

✓**Nose and Sinuses**

_____ frequent colds
_____ nasal stuffiness
_____ loss of smell
_____ hay fever
_____ discharge
_____ sinus infections
_____ nosebleeds
_____ itching

✓**Mouth and Throat**

_____ dry mouth
_____ sore tongue
_____ spots/sores in mouth
_____ heat/cold intolerance
_____ lumps in neck
_____ tonsillitis
_____ stiff neck
_____ bleeding gums
_____ hoarseness
_____ dental cavities
_____ sore throat
_____ loss of taste
_____ enlarged thyroid

Date of last dental exam? _____

✓**Respiratory**

_____ sputum
_____ hemoptysis
_____ wheezing
_____ asthma
_____ tuberculosis
_____ chest pain
_____ cough
_____ bronchitis
_____ emphysema
_____ pneumonia
_____ pleurisy
_____ difficulty breathing

Results of spirometry tests or other lung tests:

_____

_____

✓**Cardiovascular**

_____ rapid heart beat
_____ high blood pressure
_____ low blood pressure
_____ chest pain
_____ palpitations
_____ blueness of skin (cyanosis)
_____ thrombophlebitis
_____ deep leg pain
_____ slow heart beat
_____ heart murmurs
_____ rheumatic fever
_____ edema/swollen ankles
_____ difficulty breathing
_____ cold hands/feet
_____ extremity numbness
_____ leg cramps

Results of electrocardiogram or other heart tests:

_____

_____

✓**Gastrointestinal**

_____ trouble swallowing
_____ heart burn
_____ excessive hunger/thirst
_____ poor appetite/thirst
_____ diabetes
_____ nausea
_____ vomiting
_____ regurgitation
_____ vomiting of blood
_____ indigestion
_____ hepatitis
_____ ulcer
_____ excessive bloating
_____ hemorrhoids
_____ constipation
_____ diarrhea
_____ hypoglycemia
_____ abdominal pain
_____ food intolerance/allergy
_____ excessive belching
_____ passing of gas
_____ jaundice
_____ liver or gallbladder problems
_____ colitis
_____ hernias

Frequency of bowel movements? _____

Colour and size of stools? _____

Change in bowel habits? _____

Any recent bleeding or black tarry stools? _____

✓**Genito-Urinary**

_____ dark-coloured urine
_____ excessive urination
_____ burning/pain on urination
_____ pus in urine
_____ urgency
_____ dribbling
_____ urinary infections
_____ blood in urine
_____ frequency at night
_____ kidney infection
_____ foul smelling urine
_____ hesitancy
_____ incontinence
_____ kidney stones

✓**Musculoskeletal**

_____ muscle or joint pains
_____ arthritis
_____ back pain
_____ broken bones
_____ general muscle weakness
_____ stiffness
_____ gout
_____ artificial joints/limbs
_____ muscle spasms/cramps
_____ joint swelling

✓**Neurological**

_____ fainting/blackouts
_____ weakness
_____ numbness/loss of sensation
_____ tremors/involuntary motion
_____ nervousness
_____ depression
_____ difficulties concentrating
_____ convulsions/seizures
_____ loss of balance
_____ paralysis
_____ tingling/pins and needles
_____ speech problems
_____ tension
_____ memory changes/loss
_____ irritability
_____ loss of sleep

✓**Hematological**

_____ anemia
_____ easy bleeding
_____ any past transfusions
_____ easy bruising

Any other conditions?

_____

_____

**DIET**

Do you have any food allergies or sensitivities? Please list.

_____

_____

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

_____

_____

Describe a typical day's diet.

Breakfast

_____

Lunch _____

Dinner _____

Snacks _____

Beverages (and quantity)

_____

**LIFESTYLE/ENVIRONMENT**

Occupation _____

Hobbies _____

_____

Do you exercise regularly? Y N What do you do for exercise, how much, how often?

_____

_____

Are you exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

_____

_____

How would you describe the emotional climate of your home?

_____

_____

How stressful is your work or other aspects of your life? How do you manage stress?

_____

_____

Is there anything that you feel that is important that has not been covered?

_____

_____

Thank you for taking the time to complete this intake form.  We look forward to working with you in your naturopathic care.