

Naturopathic Adult Intake

PATIENT INFORMATION

Today's date (day/mo/yr): ____/____/____

Name: _____ Email: _____

Date of birth (day/mo/yr): ____/____/____ Sex: M / F

Address with postal code: _____

Tel(home): (____) _____ (work): (____) _____

Emergency contact: _____ Relationship: _____

Tel(home): (____) _____ (work): (____) _____

Medical doctor: _____ MD Tel: (____) _____

Other healthcare providers: _____

How did you hear about D. Korah, ND? Referral from: _____ Yellow pages _____
naturopathic-doctor.ca _____ holisticclinic.ca _____ Specify other: _____

Optimal health is only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist my understanding of your healthcare needs and desires.

HEALTH INFORMATION

What is your main health concern? _____

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1. _____
2. _____
3. _____

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

How do you rate your overall health? Poor Fair Good Excellent

How do you rate your overall energy? Poor Fair Good Excellent

MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?	Medication	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Supplement	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

How many courses of antibiotics have you had in the past 10 years? _____

Have you ever had a bad reaction to any medication? Y / N

MEDICAL HISTORY

Indicate if you had any of the following childhood illnesses (circle):

Asthma	Measles	Rheumatic fever
Chickenpox	Mumps	Scarlet fever
Eczema	Polio	Whooping cough
Frequent ear infections or colds	Rubella(German measles)	Other: _____

Immunizations (Check ✓)

- DPT Hemophilus influenza B Hepatitis A Hepatitis B
- Flu shot Tetanus Booster MMR Polio
- Smallpox Chicken Pox Other: _____

Any adverse reactions to vaccinations? Y / N. If yes, explain. _____

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.

Family History

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

LIFESTYLE FACTORS

Please list any dietary restrictions _____

Are you exposed to significant tobacco smoke? Y / N

Are you frequently exposed to animals? Y / N

Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. _____

Please list all allergies (food, environmental, or medications). _____

Do you exercise? Y / N

What type of exercise and how often? _____

What do you do for recreation and relaxation? _____

Occupation: _____

Marital status: _____

Number of children: _____

Describe the emotional climate of your home. _____

Rate your stress level (circle): Low Average High Unbearable

Which factors most contribute to your stress? (circle)

Health Work Money Family Marriage Other: _____

What are your spiritual or religious roots? _____

Are you an active participant with this or another group? Y / N In your everyday life, your present faith/spiritual practices are:

Not very important Somewhat important Very important

Please circle any of the following that you use.

- | | |
|-----------------------|--------------------|
| Alcohol | Diet pills |
| Antacids | Laxatives |
| Antibiotics | Pain relievers |
| Aspirin | Recreational drugs |
| Appetite suppressants | Sleeping pills |
| Birth control pills | Thyroid medication |
| Caffeine | Tobacco |
| Cortisone | Tranquilizers |

WOMEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, Pap)? Y / N
Date of last Pap?(month/yr) ____ / ____ Have you ever had an abnormal Pap? Y / N
Age of first period? _____ Is your period regular? Y / N
Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____
Do you experience PMS? Y / N Are you menopausal? Y / N. If yes, age of last period ____
Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception? _____
Have you ever had a sexually transmitted disease? Y / N
Number of pregnancies? ____ Births? ____ Miscarriages? ____ Abortions? ____
Have you had any of the following concerning your breasts?(circle)
Pain Lumps Infections Cysts Nipple discharge
Do you experience vaginal infections? Never Rarely Frequently
Do you experience bladder infections? Never Rarely Frequently
Do you have any sexual problems or concerns? Y / N. If yes, explain. _____

MEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, prostate examination)? Y / N
Date of last prostate examination?(month/yr) ____ / ____
Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception? _____
Do you have difficulty urinating completely? Y / N
How many times do you get up from your sleep to go to the bathroom at night? ____
Have you had any of the following?(circle)
Testicular pain Hernia STDs Discharge Sores
Do you have any sexual problems or concerns? Y / N. If yes, explain. _____

REVIEW OF SYSTEMS

Please **circle** if you are **currently** experiencing any of the following or write a **P** if you experienced it in the **past**.

General symptoms

- Headache
- Head injury
- Fever
- Chills
- Sweats
- Dizziness
- Fainting
- Loss of sleep
- Fatigue
- Nervousness
- Loss of weight
- Numbness or pain in arms/legs/hands
- Allergy
- Convulsions

Skin

- Hives or allergy
- Acne or skin eruptions
- Itching
- Bruises easily
- Dryness
- Boils
- Varicose veins
- Sensitive skin
- Change in mole

Kidneys & Reproduction

- Inability to control urine
- Frequent urination
- Painful urination
- Blood in urine
- Pus in urine
- Kidney infection
- Kidney stones
- Prostate trouble
- Sores on genitals

Eyes, Ears, Nose, Throat

- Dental decay
- Gum trouble
- Frequent colds
- Enlarged thyroid
- Tonsillitis
- Sore throat
- Hoarseness
- Enlarged glands
- Glaucoma
- Failing vision
- Cataracts
- Eye pain
- Ear discharge
- Deafness
- Ear ache
- Nasal drainage
- Nose bleeds
- Nasal obstruction
- Sinus infection
- Hay fever
- Mercury tooth fillings

Muscle & Joint

- Stiff neck
- Back pain
- Muscle weakness
- Swollen joints
- Painful tailbone
- Foot trouble
- Pain in shoulders
- Hernia
- Spinal curvature
- Faulty posture
- Arthritis
- Fracture/dislocation

Cardiovascular

- Low blood pressure
- High blood pressure
- Previous heart stroke
- Hardening of the arteries
- Swelling of the ankles
- Poor circulation
- Paralytic stroke
- Irregular heart beat
- Shortness of breath
- Chest pain

Gastrointestinal

- Excessive thirst
- Excessive hunger
- Belching
- Gas (flatulence)
- Nausea
- Vomiting
- Vomiting of blood
- Abdominal cramps
- Constipation
- Diarrhea
- Colon trouble
- Hemorrhoids (piles)
- Intestinal worms
- Liver problems
- Gallbladder problems
- Jaundice
- Colitis

Respiratory

- Asthma
- Chronic cough
- Spitting up phlegm
- Spitting up blood
- Difficult breathing

What are your treatment goals and expectations? _____

Is there anything else that you feel has not been covered? _____

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.