WHOLE HEALTH
NATUROPATHIC CLINIC

ADULT INTAKE FORM

Name _____ **Date** _____

Date of birth _____ (M/D/Y) Sex: M / F

Address:_____

Town/City: _____Province: _____ Postal Code:_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____

May we leave messages relating to your visits? Y / N

Emergency contact

Name: _____

Phone number:_____ Relation:_____

How did you hear about our Clinic:_____

Referred by:_____

Other health care providers you are seeing:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(____)_____	(____)_____	(____)_____

Chief Concern:

_____

_____

_____

_____

How long has this condition persisted?_____

Previous Treatment and Results_____

Other health concerns, in order of importance to you:

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

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history

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

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

_____
_____
_____
_____

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

_____
_____
_____

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

_____
_____
_____
_____

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 _____

Tobacco—form and amount/day_____

Caffeine—form and amount/day _____

Recreational drugs—what and how often_____

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

Diet

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

_____
_____
_____
_____

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

_____
_____

Describe a typical day's diet:

Breakfast_____

Lunch_____

Dinner_____

Snacks_____

Beverages (and total quantity) _____

Family history

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

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug abuse/alcoholism	
Heart disease		Thyroid Condition	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Environment

Occupation_____

Hobbies_____

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

_____

_____

_____

How many hours of sleep do you get a night: _____

Do you wake up during the night ? Y / N If so, at what time: _____

How would you describe the emotional climate of your home?

_____

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated? _____

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

_____

_____

_____

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

_____

_____