CONFIDENTIAL ADULT NATUROPATHIC INTAKE FORM

(Please fill out all relevant information to the best of your knowledge.)

Appointment Date: **Name:**

Your Health Goals & Concerns (in order of importance):

1.

2.

3.

4.

5.

Date of **Birth**: Blood Type:

Address:
City, Provice, Postal Code:

Phone (home):
(work):
Email:
I permit the Roberts Centre seasonal health newsletter to be sent to me. Yes or No

Occupation: **Nationality:**
Parents/Legal Guardian (if under 18 years of age):

How did you hear about the Roberts Centre?:

Health Insurance provider:
Naturopathic amount:

Other Health Care Providers
Provider#1:
Provider#2:

Emergency Contact Name & relation:
Address:
Phone: (home
(work)

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In your opinion, briefly explain the **state of your health**:
-
-
-
-

Have you ever been **diagnosed** with a **medical condition**? Explain
-
-
-
-

Are you on any **medications**? Y N If yes, please state **which** medication, the **dosage**, **how long** you have been taking it, and for what **conditions**.
-
-
-
-

Are the medications **helpful**? Y N Are they well **tolerated**? Y N
Please list any medications you have been on in the **past**:
-
-
-
-

Do you have any **allergies to medications**? Please explain
-
-
-

How many times have you been on **antibiotics**?
-
-
-

Illness(es) or Operation(s)	Date	Doctor / Hospital

Are you taking any **supplements, herbs, vitamins, minerals**, or **other natural remedies**?
-
-
-
-

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

Aspirin | Laxatives | Antacids
Diet pills | Birth control/implants/injection

Alcohol- how much per day or week
Tobacco- form and amount per day
Caffeine- form and amount per day
Recreational drugs- what and how often

Vaccination History: Put a check mark beside the vaccinations your child has received:

-Measles | -Diphtheria | -Chicken Pox
-Hepatitis A | -Mumps | -Pertussis
-Small Pox | -Hepatitis B | -Rubella
-Tetanus | -Influenza (Flu shot) | -Polio
-Other:____

Any **reactions** to any vaccinations?
-
-

Do you get **regular screening tests** (ie, Blood tests, Physicals, Gynecological, Prostate, and/or Breast exams)? Y N
-
-
-
-

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

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

Do you **exercise** regularly? How **often**? What **type**?
-
-
-
-
-

Environment: Please check if the following pertains to your household

- smokers | -chemicals | -old home
-renovations (present or past) | -pets | -Other toxins or hazards:
-
-

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Emotional Health: Briefly describe your **personality/disposition**
-
-
-
-

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?
-
-
-
-
-

Have you experienced any **emotional traumas** that have impacted your health?
-
-
-
-
-

Family History	Age	Health Problems	If deceased; cause, age of death
Father			
Mother			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Grandfather			
Paternal Grandmother			
Grandfather			
Other			

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<u>REVIEW OF SYSTEMS</u>: Circle "Y" if you have the concern **now**, "P" if you've had it in the **past**.

GENERAL Currant Weight: __________
Weight 1 year ago _________, when?________
Height:_________
Fever/Chills Y P
Weight Change Y P
Maximum weight _________,
Fatigue/Weakness Y P

NOSE & SINUSES Stuffiness Y P
Allergies Y P
Bleeding Y P
Hay fever Y P
Sinus problems Y P
Obstructions Y P

EARS Dizziness Y P
Impaired hearing Y P
Excess wax Y P
Other:_________
Infections Y P
Ringing Y P
Earache Y P

SKIN Itching Y P
Rashes Y P
Boils Y P
Eczema Y P
Dry skin Y P
Other: ________
Hives Y P
Acne Y P
Lumps Y P
Psoriasis Y P
Night sweats Y P, How often? ______

MOUTH & THROAT Gum problems Y P
Chancre sores Y P
Mouth dryness Y P
Hoarseness Y P
Dental cavities Y P
Loss of taste Y P
Freq sore throat Y P
Other: ___________

HEAD & NECK Headache Y P
Dizziness Y P
Swollen glands Y P
Pain or Stiffness Y P
Other: ___________
Migraine Y P
Injuries Y P
Lumps Y P
Goiter Y P

EYES Itching Y P
Double vision Y P
Glasses or contacts Y P
Tearing Y P
Cataracts Y P
Redness Y P
Bothered by sun Y P
Dryness Y P
Impaired vision Y P
Eye Pain Y P
Glaucoma Y P
Blurring Y P
Discharge Y P
Blind spot Y P

RESPIRATORY Sputum Y P
Pleurisy Y P
Tuberculosis Y P
Shortness of breath Y P
Wheezing Y P
Pain on breathing Y P
Emphysema Y P
Last chest x-ray: _________
Cough Y P
Pneumonia Y P
Last TB test: _______
Bloody sputum Y P
Difficulty breathing Y P
Asthma Y P
Bronchitis Y P
Other: _________

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REVIEW OF SYSTEMS: *continued*

GASTROINTESTINAL Difficulty swallowing Y P
Rectal bleeding Y P
Indigestion Y P
Change in thirst Y P
Nausea Y P
Constipation Y P
Obstructions Y P
Gallbladder disease Y P
Hernias Y P
Bowel movements frequency: _____
Heartburn Y P
Abdominal pain Y P
Gas/Belching Y P
Change in appetite Y P
Vomiting Y P
Diarrhea Y P
Ulcer Y P
Liver disease Y P
Hemorrhoids Y P
Other: _______________

CARDIOVASCULAR Cyanosis Y P
Heart disease Y P
Angina Y P
Rheumatic fever Y P
Swollen ankles Y P
Other: __________
Murmurs Y P
Last ECG: ______
Hypertension Y P
Chest pain Y P
Palpitations Y P

URINARY Kidney stones Y P
Blood in urine Y P
Frequency at night Y P
Urgency Y P
Hesitancy Y P
Pain on urination Y P
Frequency Y P
Inability to hold urine Y P
Frequent infections Y P
Other:__________

MUSCULOSKELETAL Joint pain/stiffness Y P
Broken bones Y P
Weakness Y P
Backache Y P
Arthritis Y P
Muscle spasm/cramps Y P
Joint swelling Y P
Other: __________

PERIPHERAL VASCULAR Cold handslfeet Y P
Varicose veins Y P
Other:_____________
Deep leg pain Y P
Thrombophlebitis Y P

NEUROLOGICAL Fainting Y P
Paralysis Y P
Numbness/Tingling Y P
Involuntary movement Y P
Speech problems Y P
Convulsions Y P
Muscle weakness Y P
Loss of memory Y P
Loss of balance Y P
Other: _____________

ENDOCRINE Excessive thirst Y P
Excessive urination Y P
Diabetes Y P
Hormone therapy Y P
Excessive hunger Y P
Excessive sweating Y P
Hypoglycemia Y P
Other: ____________

ADRENAL Fatigue/Apathy Y P
Delayed wound healing Y P
Dizziness when stand up Y P
Urination at night Y P
Nervousness Y P
Knee pain Y P
Other: _______________
Allergies Y P
Low blood pressure Y P
Frequent urination Y P
Muscular weakness Y P
Low back pain Y P
Ringing in ears Y P

THYROID Loss of hair Y P
Dry skin Y P
Goiter Y P
Low or high cholesterol Y P
Weight gain Y P
Menstrual disorder Y P
Cold intolerance Y P
Other: __________________

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REVIEW OF SYSTEMS: *continued*

LIVER Anemia Y P
Elevated cholesterol Y P
Decreased drug, alcohol, caffeine tolerance Y P
Endometriosis Y . P
Frequent headache Y P
Constipation Y P
Eye problem Y P
Other: _______________
Hypertension Y P
Low energy before eating Y P
PMS Y P
Heavy menses Y P
Skin problems Y P
Chronic muscle tension Y P
Difficulty digesting fatty foods Y P

PANCREAS Food allergies Y P
Maldigestion Y P
Bowel gas Y P
Other: ______________
Blood sugar abnormalities Y P
Undigested food in stool Y P
Stool floats Y P

PARATHYROID Osteoporosis Y P
Gum/tooth disease Y P
Ridged nails Y P
Joint pain Y P
Kidney stones Y P
Other: ____________

BLOOD & L YMPHA TIC
Anemia Y P
Transfusions Y P
Lymph node swelling Y P
Bleed/bruise easily Y P
Clotting problem Y P
Other:___________

BREASTS Lumps Y P
Self Exam Y P
Tenderness Y P
Other: ___________

REPRODUCTIVE Sexually active Y P
Veneral disease Y P
Sexual difficulties Y P
Other: __________

MALE Prostate symptoms Y P
Testicular mass Y P
Urgency Y P
Dribbling Y P
Discharge or sores Y P
Impotence Y P
Hernia Y P
Incomplete urination Y P
Decreased libido Y P
Other :__________

PSYCHOSOCIAL Depression Y P
Anxiety Y P
Phobias Y P
Alcohol/Drug abuse Y P
Mood swings Y P
Tension Y P
Sleep problems Y P
Other: ___________

Is there **anything else** you'd like to mention that was not asked? Please explain:

-
-
-
-
-
-

Thank you, this concludes the intake form.

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