**Adult Intake Form**

Name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_Date:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Date of Birth: (DD/MM/YY)\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Age: \_\_\_\_\_\_\_ Gender:\_\_\_\_\_\_

Address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Email Address (optional):\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Telephone number: Home:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Cell:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

May we leave a message at these numbers? Y N

Occupation:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Emergency contact: Name\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Phone number\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How did you hear about Martin Wellness?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all other health care providers you see: (include name, title and phone number)

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Have you ever had previous naturopathic care? Y N

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

Major Health Concerns in order of importance:

|  |
| --- |
| 1. |
| 2. |
| 3. |
| 4. |

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

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any allergies (to foods, medicines, environmental, etc.)? Please explain:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please list all current medications and date started:

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Prescription Drugs | Over-the-counter Drugs | Supplements (mineral, vitamin etc) | Herbal Medicines | Homeopathic Medicines |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |
|  |  |  |  |  |

Are you currently following a special diet/have any dietary restrictions?\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

How many times have you been treated with Antibiotics? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

When was your last physical exam? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Do you have any other screening tests done regularly? (ex. PAP, prostate exam, breast

exam, mammogram, blood work, etc. )

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Alcohol—how much/day or week \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Tobacco—form and amount/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Caffeine—form and amount/day \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Recreational drugs—what and how often\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please indicate the immunizations you have had (Ontario vaccine schedule dates appear next to each immunization):

□ DPT (Diphtheria, pertussis, tetanus) – 2,4,6 & 18 months

□ Rotavirus – 2 & 4 months

□Haemophilus Influenza B – 2,4,6, 8 months

□Pneumococcal Conjugate - 2, 4, & 12 months

□ Meningicoccal Conjugate – 12 months (ACYW version – grade 7)

□ Chicken Pox – 15 months, 4-6 years

□ Tetanus booster (14-18 years) When?\_\_\_\_\_\_

□ MMR (measles, mumps, rubella) – 1 year, 4 – 6 years

□ Seasonal Influenza – Every year

□ Polio – 4 – 6 years

□ Hepatitis B – Grade 7

□ HPV – Grade 8

□ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Did you experience any adverse reactions to the vaccines? Y N

**Personal & Family medical history:**

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

|  |  |  |  |
| --- | --- | --- | --- |
| Condition | Who? | Condition | Who? |
| Allergies |  | Depression |  |
| Asthma |  | Anxiety |  |
| Heart Disease |  | Drug Addiction |  |
| High Blood Pressure |  | Alcohol Addiction |  |
| Autoimmune |  | Kidney Disease |  |
| Cancer |  | Diabetes |  |
| Seizures |  | Other |  |

□ I don’t know my family medical history

**Environment**

Hobbies \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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 or have you ever been regularly exposed to solvents, heavy metals, fumes

pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What is your stress level? (please rate out of 10 with 10 being highest) \_\_\_\_\_\_\_\_\_\_\_\_

How do you deal with stress? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Please rate your level of satisfaction with each of the following areas in your life:

( 1 = Not satisfied, 4 = highly satisfied)

HEALTH 1 2 3 4

DIET 1 2 3 4

LIFESTYLE 1 2 3 4

WORK 1 2 3 4

FAMILY 1 2 3 4

RELATIONSHIPS 1 2 3 4

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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**SYSTEMS REVIEW**

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer completely as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your appointment. **Please check (√) “C" if you currently have the symptom or "P" if you have had it in the past 6 months.**

|  |  |  |
| --- | --- | --- |
| **Skin** | **C** | **P** |
| Rashes |  |  |
| Hives |  |  |
| Acne |  |  |
| Boils |  |  |
| Eczema |  |  |
| Psoriasis |  |  |
| Dry Skin |  |  |
| Itching |  |  |
| Lumps |  |  |
| Night Sweats |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Head** | **C** | **P** |
| Tension headaches |  |  |
| Migraines |  |  |
| Head Injury |  |  |
| Dizziness |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Eye** | **C** | **P** |
| Impaired Vision |  |  |
| Use Contacts/glasses |  |  |
| Eye Pain |  |  |
| Tearing |  |  |
| Dryness |  |  |
| Double vision |  |  |
| Glaucoma |  |  |
| Cataracts |  |  |
| Blurring |  |  |
| Light Sensitivity |  |  |
| Itching |  |  |
| Redness |  |  |
| Discharge |  |  |
| Blind spot |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Ears** | **C** | **P** |
| Impaired hearing |  |  |
| Earache  |  |  |
| Discharge |  |  |
| Infections |  |  |
| Excessive Wax |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Nose & Sinuses** | **C** | **P** |
| Frequent colds |  |  |
| Nose bleeds |  |  |
| Stuffiness |  |  |
| Hay Fever |  |  |
| Infections |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Mouth & Throat** | **C** | **P** |
| Hoarseness |  |  |
| Gum problems |  |  |
| Sores |  |  |
| Dryness |  |  |
| Sore throat |  |  |
| Loss of taste |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Neck** | **C** | **P** |
| Lumps |  |  |
| Swollen glands |  |  |
| Goiter |  |  |
| Pain or Stiff |  |  |
| other |  |  |

|  |  |  |
| --- | --- | --- |
| **Respiratory** | **C** | **P** |
| Cough |  |  |
| Sputum/Phlegm |  |  |
| Spit up blood |  |  |
| Wheeze |  |  |
| Asthma |  |  |
| Bronchitis |  |  |
| Pneumonia |  |  |
| Pleurisy |  |  |
| Emphysema |  |  |
| Pain w Breathing |  |  |
| Short of breath |  |  |
| Positive tuberculin test |  |  |
| Last TB test |  |  |
| Lest chest x-ray |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Cardiovascular** | **C** | **P** |
| Angina |  |  |
| Murmurs |  |  |
| Chest pain |  |  |
| Swollen ankles |  |  |
| Palpitations, fluttering |  |  |
| Last ECG |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Breasts** | **C** | **P** |
| Do you perform self breast exams? |  |  |
| Lumps |  |  |
| Tenderness |  |  |
| Nipple discharge |  |  |
| Date of Last Mammogram |  |
| Other |  |

|  |  |  |
| --- | --- | --- |
| **Gastrointestinal** | **C** | **P** |
| Vomiting |  |  |
| Heartburn |  |  |
| Change in appetite |  |  |
| Nausea |  |  |
| # of Bowel movements/day:  |
| Vomiting blood |  |  |
| Belching |  |  |
| Passing gas |  |  |
| Abdominal Pain |  |  |
| Indigestion |  |  |
| Diarrhea |  |  |
| Constipation |  |  |
| Blood in stools |  |  |
| Hemorrhoids |  |  |
| Black tarry stool |  |  |
| Jaundice |  |  |
| Liver disease |  |  |
| Gallbladder disease  |  |  |
| Food allergy |  |  |
| Hiatus hernia |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Blood/Lymph** | **C** | **P** |
| Anemia |  |  |
| Easy bleed/bruise |  |  |
| Past infusions |  |  |
| Lymph node swelling |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Urinary** | **C** | **P** |
| Pain on urination |  |  |
| Increased frequency |  |  |
| Frequency at night |  |  |
| Urgency |  |  |
| Leakage |  |  |
| Frequent UTI |  |  |
| Blood in urine |  |  |
| Reduced urine flow |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Musculoskeletal** | **C** | **P** |
| Broken bones |  |  |
| Muscle cramps/spasms |  |  |
| Weakness |  |  |
| Joint swelling |  |  |
| Backache |  |  |
| Joint pain |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Peripheral vascular** | **C** | **P** |
| Deep leg pain |  |  |
| Cold hands/feet |  |  |
| Varicose veins |  |  |
| Leg cramps |  |  |
| Numbness |  |  |
| Ulcers |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Neurologic** | **C** | **P** |
| Fainting |  |  |
| Seizure/convulsions |  |  |
| Paralysis |  |  |
| Muscle weakness |  |  |
| Loss of memory |  |  |
| Involuntary movements |  |  |
| Loss of balance |  |  |
| Speech problems |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Endocrine** | **C** | **P** |
| Heat/cold intolerance |  |  |
| Thyroid trouble |  |  |
| Excess thirst |  |  |
| Excess hunger |  |  |
| Excess sweating |  |  |
| diabetes |  |  |
| Low blood sugar |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Emotional** | **C** | **P** |
| Depression |  |  |
| Extreme anger |  |  |
| Mood swings |  |  |
| Anxiety |  |  |
| Nervousness |  |  |
| Tension |  |  |
| Phobias |  |  |
| Insomnia |  |  |
| Sexual difficulties |  |  |
| Drug abuse |  |  |
| Psychiatric care |  |  |
| Psychological counselling |  |  |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Female Reproductive** | **C** | **P** |
| Bleeding between periods |  |  |
| Irregular cycle |  |  |
| PMS |  |  |
| Heavy flow |  |  |
| Painful menses |  |  |
| Menopause |  |  |
| Hormone therapy |  |  |
| Difficulty conceiving |  |  |
| Vaginal discharge |  |  |
| Vaginal itching |  |  |
| Sexually active |  |  |
| Painful intercourse |  |  |
| Age of first menses: |
| Last menstrual period: |
| #of days period lasts: |
| Length of cycle: |
| Last gynecological exam: |
| #of pregnancies: |
| #of live births: |
| #of miscarriages: |
| # of abortions: |
| Circle preference: Heterosexual Homosexual Bisexual |
| Other |  |  |

|  |  |  |
| --- | --- | --- |
| **Male Reproductive** | **C** | **P** |
| Hernia |  |  |
| Testicular mass |  |  |
| Testicular pain |  |  |
| Impotence |  |  |
| Premature ejaculation |  |  |
| STI |  |  |
| Sores |  |  |
| Sexually active |  |  |
| Circle sexual preference: Heterosexual Homosexual Bisexual |
| Last prostate exam: |
| Last PSA level: |