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**Adult Patient Intake Form**

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| Last Name: | | | First Name: | | | | | | Middle Name: | |
| Date of Birth  (MM/DD/YYYY): | | | Age: | | | Gender: | | | Occupation: | |
| **Contact Information** | | | | | | | | | | |
| Full Address: | | | | | | | City, Province: | | | |
| Postal Code: | Daytime phone #: | | | Evening phone #: | | | | | | May we leave messages regarding your visit? Yes / No |
| Email: | | | | | | | | | | May I contact you by email? Yes / No Initials: |
| **Emergency Contact Information** | | | | | | | | | | |
| 1) Last Name: | | First Name: | | | | | | Relationship: | | |
| Daytime phone #: | | | | | | Evening phone #: | | | | |
| 2) Last Name: | | First Name: | | | | | | Relationship: | | |
| Daytime phone #: | | | | | | Evening phone #: | | | | |
| **Other Healthcare Providers** | | | | | | | | | | |
| 1) Name:  Specialty/Focus:  Phone #: | | 2) Name:  Specialty/Focus:  Phone #: | | | | | | 3) Name:  Specialty/Focus:  Phone #: | | |
| Date of last doctor visit: | | | | | Date of last physical exam: | | | | | |
| Please list regular screening tests performed by other physicians: | | | | | | | | | | |

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| How did you hear about this clinic? | |
| If referred, please state by whom: | |
| Have you been treated by a Naturopathic Doctor before: Yes / No | |
| If yes, by whom? | Date of last visit to ND: |

**Health Assessment Questionnaire**

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| **In your opinion, what are your most important health concerns:** |
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |

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| **Medical History** | | | | | | | | |
| If you are female, are you pregnant? Yes / No | | | Are you trying to become pregnant? Yes / No | | | | | |
| Height: | Current Weight: | | Past Min. Weight: | | | Past Max. Weight: | | |
| **List previously diagnosed medical conditions:** | | | | **Treatment Received** | | | | **Year** |
| 1) | | | |  | | | |  |
| 2) | | | |  | | | |  |
| 3) | | | |  | | | |  |
| 4) | | | |  | | | |  |
| 5) | | | |  | | | |  |
| **List all allergies (medications, foods, supplements, environmental, etc.)** | | | | | **Reaction Type** | | | |
| 1) | | | | |  | | | |
| 2) | | | | |  | | | |
| 3) | | | | |  | | | |
| 4) | | | | |  | | | |
| **5)** | | | | |  | | | |
| **List all prescription drugs** (oral contraceptive, etc.), **over-the-counter medications** (pain killers, antacid, etc.), **herbs and natural supplements** (vitamins, homeopathics, etc.) that you are taking – can send a photo if easier or bring them to your appointment | | | | | | | | |
| **Medication (please include brand)** | | **Dosage** | | | | | **Start Date** | |
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| **Family Medical History** | | | | | |
| Please include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information. | | | | | |
|  | **Age** | **Health History** |  | **Age** | **Health History** |
| **Father** |  |  | **Mother** |  |  |
| **Grandmother (Paternal)** |  |  | **Grandmother**  **(Maternal)** |  |  |
| **Grandfather**  **(Paternal)** |  |  | **Grandfather**  **(Maternal)** |  |  |
| **Your Siblings** |  | F/M | **Your Children if applicable** |  | F/M |
|  | F/M |  | F/M |
|  | F/M |  | F/M |
|  | F/M |  | F/M |

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| **Dietary and Lifestyle Habits** | | |
| **Exercise** | How many times do you exercise per week? Never 1x 2x 3x 4x 5x >5x | |
| What type of exercise? Strength Building Cardio/Aerobic Stretching | |
| **Diet** | Are you currently dieting? Yes / No | Is it a physician prescribed diet: Yes / No |
| Do you have any dietary restrictions (religious, sensitivities/intolerances/vegan/vegetarian)? | |
| On average, how many meals do you have in a day? 1 2 3 4 5 >5  **Please describe a typical day’s diet (include approximate times):**  Breakfast  Lunch  Dinner  Snack(s) | |
|  | Water intake (in cups or liters):  Do you have any food cravings and when do they occur? | |
| **Relationships and Sexuality** | Are you currently sexually active? Yes / No | |
| Describe your sexuality: Heterosexual Homosexual Bisexual Transgender | |
| List contraceptive method(s) used, if any: | |
| Do you experience any pain or discomfort during intercourse? Yes / No | |

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| **Caffeine** | # of cups of the following consumed in a day:  Coffee: #\_\_\_\_\_\_\_\_ Tea: #\_\_\_\_\_\_\_\_ Cola:#\_\_\_\_\_\_\_\_ Other: \_\_\_\_\_\_\_\_\_\_\_\_\_\_ #\_\_\_\_\_\_\_\_ | | |
| **Alcohol** | Do you consume alcohol? Yes / No | If yes, how many drinks/week? | |
| What type(s) of alcohol do you consume? | | |
| **Tobacco** | Do you use tobacco? Yes / No | | If yes, how many/day? |
| What type(s) of tobacco? | | How many years? |
| Are you exposed to second hand smoke? Yes / No | | |
| **Drugs** | Do you currently use recreational drugs? Yes / No | | |
| If yes, which kind(s) and how often? | | |

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| **Sleep** | On average, how many hours of sleep do you get? | |
| Do you have trouble falling asleep? Yes / No | |
| Do you wake up during the night? Yes / No | If yes, how many times/night? |
| **Digestion** | # bowel movements per day? If not daily, how many per week? ­­­\_\_\_\_\_  Any straining or pain?  Form (circle all that apply): Diarrhea / Loose pieces / One well-formed piece / Hard pieces  Do you see any of the following in your stool? Blood / Mucus / Undigested food  Do you experience any of the following: Bloating / Gas / Heartburn | |
| **Energy** | On a scale of 1 (lowest) to 10 (highest), rate your energy level  Best time of day?  Worst time of day?  Do you wake feeling refreshed? Yes / No | |
| **Stress** | What are some stressors in your life? | |
| **Toxins** | Are you regularly exposed to any toxins or other hazards? Please specify. | |

**Is there any other important information that you would like me to know?**

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