Adult Intake Form

Mountain Health Team
Helping you feel better

Please complete this form before your first visit

Name:_____ **Date**: _____

Date of Birth: _____ (MM/DD/YYYY) **Gender**: _____ **Marital status**: _____

Address: _____

_____

Email address: _____

Home telephone number: _____ **Work telephone**: _____

Emergency contact name: _____ **Relation**: _____

Emergency contact phone number: _____

May we leave messages relating to your visits? Y N **If yes, which number?** _____

How did you hear about our clinic? _____

Other health care providers you are seeing:

1. _____ 2._____ 3._____

_____ _____ _____

_____ _____ _____

(____)_____ (____)_____ (____)_____

What are your health concerns in order of importance to you:

1. _____. First noticed: _____
2. _____. First noticed: _____
3. _____. First noticed: _____
4. _____. First noticed: _____
5. _____. First noticed: _____

Please list two or three expectations you have from your Naturopathic Doctor *on the first visit*:

_____

_____

Please describe the *long-term* expectations that you have from your Naturopathic Doctor:

_____

_____

Personal Medical History

What was the date of your last physical exam? _____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.?) Yes No

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 approximate dates.

_____

_____

Please list any allergies (medicines, environmental, foods, etc.?) _____

_____

Please list current Medications and Supplements (prescriptions, vitamins, herbs, homeopathics, etc.)

Medication/Supplement	**Dose/day**	**How long**	What for?

Please list past prescription medications _____

_____

How many times have you been treated with antibiotics? _____

Alcohol – how much/day or week: _____

Tobacco – form and amount/day: _____

Caffeine – form and amount/day: _____

Recreational or street drugs – what type and how often: _____

Health Habits

Current weight:_____ **Height**: _____ **Heaviest weight?** (**when?**):_____

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

On a scale of 1-10, with 10 being the best, how would you rate your energy level? _____

What is your religion or personal philosophy? _____

Exercise

How often do you exercise per week: _____ **For how long**: _____

What type of exercise: _____

Diet

Do you have any food allergies, intolerances or sensitivities? Please list

_____

Do you crave any foods? _____

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

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Supper: _____

Snacks: _____

Beverages: (and total quantity): _____

How often do you eat out per week? _____ **What is your favourite place?**_____

Sexual History

If you are female, are you currently pregnant? Yes No

Are you sexually active? Yes No

If sexually active, are you trying to conceive? Yes No

If not trying for a pregnancy, please list the type of contraception used: _____

Family History

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

Condition	Please indicate family member	Age of onset?
ADD/ADHD		
Allergies		
Anxiety or Depression		
Asthma		
Alzheimer's Disease		
Arthritis		
Cancer		
Diabetes		
Digestive (Colitis, Crohn's, etc.)		
Drug or Alcohol abuse		
High Blood Pressure		
Heart Disease		
Kidney disease		
Skin Problems		
Thyroid Diseases		
Other conditions/diseases:		

☐ Check here if your family history is unknown

Environment

Occupation: _____ **Do you enjoy your job?** Yes No Sometimes

How stressful is your occupation? _____

Hobbies you enjoy: _____

Hours spent watching TV, texting/cellphone or on computer per day: _____(Total hours)

How would you describe the emotional atmosphere in your home? _____

Are you exposed to significant tobacco smoke (work, home, etc.)? Yes No

Are you exposed to significant environmental pollutants (strong scents, cosmetics, molds, herbicides/pesticides, welding fumes, etc.)? Yes No. **If yes, please describe**:

_____

_____

Are you frequently exposed to animals? Yes No _____

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

_____

_____

_____

_____

_____

_____

Would you like to learn more about (please check if interested):

- ❑ Botanical medicine
- ❑ Naturopathic spine/joint manipulation
- ❑ Nutritional counseling
- ❑ Western acupuncture applications
- ❑ Reasoning behind ND's in Canada attaining prescription rights
- ❑ Environmental Medicine

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