ADULT NATUROPATHIC INTAKE FORM

Dr. Laura Batson, ND

GENERAL INFORMATION

Name: ____ Date: _______________________________

Address: ____

City: ___________________________ Province: _______________ Postal Code: ______________________

Email address: ____

Phone: (Home) __________________ (Work) ____________________ (Cell) ___________________________

Please indicate your reminder preference: ☐ email ☐ phone call ☐ text **If text,** indicate cell carrier: __________

Would you like to subscribe to our monthly newsletter for stretches, chiropractic tips, and recipes? ☐ Yes ☐ No

Age: ___________ Date of birth (month/day/year): _________________________ Gender: _____________

Marital status: __Single __ Married __ Partnership __ Common law __ Separated __ Divorced __ Widowed

Name of Spouse: ____________________________ Number of children: __________

EMERGENCY CONTACT

Name: ____ Relationship: _________________________

Phone: (Home) __________________ (Work) ____________________ (Cell) _________________________

Address: ____

OTHER HEALTH CARE PROVIDERS (family doctors, specialists, complimentary health care providers):

Name	Role	Phone number	Address

When was your last physical exam? ____

When was your last blood work done? ____

CURRENT HEALTH CONCERNS (in order of importance):

1. ____

2. ____

3. ____

PERSONAL AND FAMILY MEDICAL HISTORY

Are you or any member of your immediate family experiencing (or have experienced) the following conditions:

Condition	Which family member?	Condition	Which family member?
Alcoholism/drug addiction		Allergies	
Anemia		Arthritis	
Asthma		Autoimmune disease	
Cancer (specify type)		Crohn's/Colitis	
Diabetes		Digestive concerns	
Epilepsy		Headaches	
Heart disease		Hepatitis	
High blood pressure		Kidney disease	
Mental illness (please specify)		Osteoporosis	
Skin conditions		Stroke	
Thyroid disease (hyper/hypo)		Tuberculosis	
Others:			

___I don't know my family medical history

What hospitalizations, injuries, or surgeries have you had? When did they occur?

____

____

What was your general state of health as a:

Child ____

Teenager ____

Adult ____

ALLERGIES

List any allergies that you currently have or have had in the past (environment, food, drugs, other):

____

Are you exposed to toxic chemicals at work or home on a regular basis? ______________________________

Have you ever been exposed to heavy metals such as lead, arsenic, or mercury? _________________________

MEDICATIONS AND SUPPLEMENTS

Please list any *medications* you are currently taking, either prescribed or over the counter:

Medication	Reason	Amount	How long

Please list any *supplements* you are currently taking:

Supplement	Reason	Amount	How long

How many times have you been on antibiotics in the past 10 years? ___________________________________

GENERAL AND LIFESTYLE

How much alcohol do you consume per week?

How much caffeine do you consume per week?

How much tobacco do you consume per week?

How much cannabis do you consume per week?

How much water do you consumer per day?

How much exercise do you get per week?

What kind of exercise do you do?

How would you describe the emotional climate of your home?

How would you rate your stress on a scale of 1-10 (10=worst)

How would you rate your energy on a scale of 1-10 (10=best)

Current height and weight:

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

____

REVIEW OF SYSTEMS Please indicate Y (Yes) if you are currently experiencing the symptom or P (Past) if it is a past symptom.

SKIN	**Y**	**P**	**MOUTH/THROAT**	**Y**	**P**	**DIGESTIVE SYSTEM**	**Y**	**P**	**FEMALE REPROD.**	**Y**	**P**
Rashes			Gum problems			Difficulty swallowing			Low libido		
Dryness			Sores in mouth			Nausea			Irregular periods		
Hives			Periodontal disease			Vomiting			Painful periods		
Itching			Sore tongue/mouth			Diarrhea/loose stools			Spotting		
Change in lump/mole			Thrush			Constipation			Excessive flow		
Acne			Frequent sore throat			Blood in stool			Vaginal discharge		
Easy bruising			Enlarged lymph nodes			Mucous in stool			Vaginal itching		
Other			Loss of taste			Poor appetite			STD's		
HEAD/NECK	**Y**	**P**	Hoarseness			Excessive hunger			PMS		
Headaches			Other			Excessive belching			Painful intercourse		
Head injury			**RESPIRATORY**	**Y**	**P**	Bloating/gas			Fibroids		
Vertigo/Dizziness			Chronic cough			Indigestion			Breast lump		
Jaw pain			Coughing mucous			Acid reflux			Breast pain		
Neck pain			Coughing blood			Hemorrhoids			Fibrocystic breasts		
Other			Difficulty breathing			Eating disorder			Nipple discharge		
EYES	**Y**	**P**	Shortness of breath			Ulcer			Breast cancer		
Impaired vision			Pain on inhalation			Abdominal pain			Hot flashes		
Eye pain			Asthma			Hernias			Difficulty conceiving		
Redness			Bronchitis			Other			Age of first menses		
Excessive tearing			Pneumonia			**MUSCLES & JOINTS**	**Y**	**P**	# days of menses		
Dryness			Frequent colds			Muscle pain			# of pregnancies		
Blurred/Double vision			Other			Muscle cramps			# of live births		
Spots or floaters			**CARDIOVASCULAR**	**Y**	**P**	Joint pain			# of miscarriages		
Discharge			Heart disease			Joint stiffness			# of abortions		
Glaucoma			Angina			Low back pain			Last PAP test		
Cataracts			High blood pressure			Arthritis			Last menses		
Other			High cholesterol			**URINARY GENITAL**	**Y**	**P**	**MENTAL/EMOTIONAL**	**Y**	**P**
EARS	**Y**	**P**	Rapid heart rate			Painful urination			Difficult concentration		
Impaired hearing			Murmurs			Difficult urination			Irritability		
Infection			Chest pain			Frequent urination			Frustration/anger		
Ringing			Palpitations			Incontinence			Personality changes		
Pain			Heart attack			Frequent infections			Poor memory		
Discharge			Stroke			Blood in urine			Anxiety/panic		
Other			**NERVOUS SYSTEM**	**Y**	**P**	Kidney stones			Stress		
NOSE/SINUSES			Fainting			**MALE REPRODUCTIVE**	**Y**	**P**	Depression		
Nose bleeds			Paralysis			Low libido			**GENERAL**	**Y**	**P**
Nasal discharge			Tremors			Discharge			Fatigue		
Frequent sneezing			Poor balance			Hernia			Chills		
Loss of smell			Seizures			Enlarged prostate			Insomnia		
Sinus infections			Dizziness			Testicular mass			Excessive sleep		
Other			Weakness			PSA test			Night sweats		
			Numbness			STD's			Weight loss		
			Other			Other			Weight gain		