NICKEL RIDGE PHYSIOTHERAPY

MASSAGE THERAPY - NATUROPATH

Naturopathic Medicine - Adult Intake Form

Please take the time to fill out the following intake that is designed to provide insight into your health. When embarking on a personal health plan, it is important to have a benchmark of where you are, your personal and family history and what your behaviors, concerns, and thoughts are with regards to your health. All information is kept confidential.

GENERAL INFORMATION

Full name: _____ Date: _____

Date of birth: _____ Age: _____ Sex: M F

Email Address: _____

Complete Address: _____

City: _____ Postal Code: _____

Tel. No.: Home: _____ Work: _____

Cell: _____

May we leave a message relating to your visit? Y or N Which number?_____

Occupation: _____ Full-time or Part-time?_____

Marital Status: single married separated divorced other: _____

Children: yes / no If yes, please list ages: _____

In case of emergency contact: _____

Relationship to emergency contact: _____ Tel. No. of emergency contact_____

How/where did you hear about naturopathic medicine at this clinic? _____

A. PRESENT HEALTH CONCERNS

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

1) _____
2) _____
3) _____
4) _____
5) _____

When did you notice any changes in your health?

Have you been diagnosed with any illnesses? Past or present.

Please list all **current** medications (prescription, over the counter, vitamins, herbs, homeopathy etc.). Include when you started the medication, the name, the brand (if applicable) and the dosage.

Please list **past** prescription medications. Include when you started and ended, the name and dosage.

Please list your current primary physician or health care practitioner:

When was your last blood test, and what was it for?

Other health care providers you are seeing?

B. PAST HEALTH CONCERNS

Please list all injuries, surgeries, hospitalizations, accidents or medical procedures that you have had (include dates):

1.
2.
3.
4.
5.

List any known current or previous allergies (including food, drugs, herbs, environmental etc.)

How many times have you been treated with antibiotics? _____

Please indicate what immunizations you have had:

□ DPT (diphtheria, pertussis, tetanus) □ Haemophilus Influenza B □Small pox
□ Hepatitis A □ Hepatitis B □ HPV
□ MMR (measles, mumps, rubella) □ Flu vaccine
□ Tetanus booster _____(when) □ Polio

Other vaccines:_____
Any vaccination reactions: _____

C. FAMILY HEALTH HISTORY

Indicate if anyone in your family has been diagnosed with any health problems (examples**:** high blood pressure, cholesterol, cancer, diabetes, asthma, thyroid, autoimmune diseases, depression, anxiety, heart attacks, etc.):

Mom: _____

Dad: _____

Maternal Grandma: _____

Maternal Grandpa: _____

Paternal Grandma: _____

Paternal Grandpa: _____

Uncle(s): _____

Aunt(s): _____

Brother(s): _____

Sister(s): _____

D. LIFESTYLE INFORMATION

❑ use tobacco ❑ contact with tobacco smoke
❑ use alcohol ❑ use caffeinated beverages
❑ use marijuana ❑ use "recreational" drugs

What behaviors or habits do you currently engage in that **support** your health?

_____

_____

What behaviors or habits do you currently engage in that **are destructive** to your health?

_____

_____

Exercise

How active is your day?_____
How many hours of exercise do you do per week? _____
Do you belong to a gym? □ YES □ NO
What forms of exercise do you do? (Mind/body, strength training, cardiovascular exercise, flexibility training)? _____

_____

Energy

On a scale of 0-10 (low to high) rate your energy? _____

Do you experience daily fatigue? _____

Sleep

What is your bedtime? _____

What time do you wake up? _____

Do you wake up in the middle of the night? Y N How often? _____

What is the reason? _____

Stress

On a scale of 1 -10 (low to high) rate your stress? _____

What are current sources of stress in your life? (ex. work, spouse, friends, etc.)_____

_____

E. DIETARY INFORMATION

On a scale of 1-10 (poor to good nutrition) how would you rate your diet? _____

Is there anything in your diet you would like to change?_____

Do you follow any specific diet regime (vegetarian, vegan, paleo, weight watchers, etc.) _____

Do you avoid certain foods? _____

Are you aware of any differences in how you feel with different foods? _____

_____

F. REVIEW OF SYSTEMS

Present Weight: _____Weight one year ago:_____Height: _____

Maximum weight and when:_____

Minimum weight as adult & when: _____ Ideal Weight: _____

SKIN Y= Yes; N=No; P=Past Concern

Rashes or itchy skin:	Y N P		Rosacea:	Y N P
Hives:	Y N P		Acne:	Y N P
Psoriasis:	Y N P		Eczema	Y N P
Oily/dry skin (circle which):	Y N P		Warts:	Y N P
Nail Changes:	Y N P		Perspiration:	Y N P

HEAD

Headache:	Y N P		Migraines:	Y N P
Dandruff:	Y N P		Head Injury:	Y N P
Oily/dry hair (circle which):	Y N P		Hair loss:	Y N P
Dizziness:	Y N P		Frequent sore throat:	Y N P

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NOSE

Frequent Colds:	Y N P		Nosebleeds:	Y N P
Congestion:	Y N P		Post Nasal Drip:	Y N P
Polyps:	Y N P		Seasonal Allergies:	Y N P

EYES

Watery:	Y N P		Blurry Vision:	Y N P
Double Vision	Y N P		Itchy or dry:	Y N P
Strain:	Y N P		Do you wear glasses:	Y N P

MOUTH/THROAT

Canker sores or cold sores:	Y N P		Bad Breath:	Y N P
Loss of smell or taste:	Y N P		Gum disease:	Y N P
Hoarseness:	Y N P		Cavities:	Y N P

NECK

Stiffness:	Y N P		Swollen Glands:	Y N P
Full movement:	Y N P		Tension:	Y N P

RESPIRATORY

Shortness of breath lying/sitting:	Y N P		Shortness of breath with exertion:	Y N P
Painful breathing:	Y N P		Asthma:	Y N P
Wheezing:	Y N P		Painful breathing or chest pain:	Y N P

CARDIOVASCULAR

High Blood Pressure:	Y N P		Chest Pain:	Y N P
Low Blood Pressure	Y N P		Murmurs:	Y N P
Arrhythmias or palpitations:	Y N P		Swelling in body:	Y N P

URINARY TRACT

Incontinence:	Y N P		Pain with Urination	Y N P
Frequent Infections:	Y N P		Kidney Stones	Y N P
Urgency:	Y N P		Discharge/Blood (circle):	Y N P

GASTROINTESTINAL

Heartburn:	Y N P		Bowel Movements Per Day:	
Indigestion or bloating:	Y N P		Constipation	Y N P
Vomiting:	Y N P		Diarrhea:	Y N P
Nausea:	Y N P		Hemorrhoids:	Y N P

MALE REPRODUCTIVE SYSTEM

Testicular pain/swelling:	Y N P		Healthy libido?	Y N P
Hernia:	Y N P		S.T.D.:	Y N P
Penile discharge	Y N P		Prostate symptoms	Y N P
Impotency:	Y N P		Sexual Orientation:	

FEMALE REPRODUCTIVE SYSTEM

Age Period Began:			Length of period:	
PMS:	Y N P		Menstrual Pain:	Y N P
How many times pregnant?			How many births?	
Miscarriages?			Abortions?	
Last Pap Smear (date):			Sexual Orientation:	
Any abnormal PAP:	Y N P		Age of menopause:	
Use of birth control (past or present):			Healthy libido?	Y N P

MUSCULOSKELETAL

Weakness:	Y N P		Arthritis:	Y N P
Stiffness:	Y N P		Leg Cramps:	Y N P
Tremors:	Y N P		Pain:	Y N P

NERVOUS SYSTEM

Paralysis:	Y N P		Sciatica:	Y N P
Tingling/numbness:	Y N P		Carpal tunnel syndrome:	Y N P
Seizures:	Y N P		Fainting:	Y N P

MENTAL/EMOTIONAL

Depression:	Y N P		Anger/irritability:	Y N P
Suicidal:	Y N P		High-strung/tense:	Y N P
Anxiety:	Y N P		Fear/Panic	Y N P
Eating disorder:	Y N P		Psych Hospitalization:	Y N P

G. ENVIRONMENTAL INFORMATION

Did you grow up near any refinery or polluted area? If so, what sort of pollution were you exposed to? _____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?

Are you particularly sensitive to perfumes, gasoline or other vapors? _____

H. ADDITIONAL INFORMATION

What potential obstacles do you foresee that will prevent you from making healthy lifestyle changes (family, work, etc.)?

Why did you choose to come to this clinic? _____

What are your expectations from this clinic and our naturopathic doctor? _____