Nickel Ridge Physiotherapy
Naturopath - Massage Therapy

Adult Intake Form

Name:_____ Age:_____ Birth date:_____M ☐ F ☐ Other ☐

Address: _____City: _____ Postal: _____

Home Phone #: (____)_____Work #: (____)_____

E-mail: _____ Preferred method of contact: Home # ☐ Work # ☐ Email ☐

Occupation + hours per week:_____

Emergency Contact name, phone #, and relationship to you:_____

Marital Status: _____Children?_____

Have you received naturopathic care in the past? _____

How did you hear about this clinic?_____

What are your chief concerns? (Please list them in order of importance to you)

1. _____
2. _____
3. _____

Previous Treatments and results? _____

Your Medical History

How would you describe your general state of health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please check the following that apply to you:

☐ Cancer	☐ Diabetes	☐ Surgeries	☐ Depression
☐ High blood pressure	☐ Seizures	☐ Other major illness	☐ Asthma
☐ Heart disease	☐ Hepatitis	☐ Venereal disease	☐ Allergies
☐ Rheumatic fever	☐ Thyroid Disease	☐ Arthritis	☐ Alcoholism
☐ Significant trauma (auto accidents, falls, other)		☐ HIV	☐ Other

☐ Vaccinations (including dates)? _____

☐ Other health care providers: _____

Family Medical History (please write the family member beside checked category, eg/ "mother")

☐ Cancer_____	☐ High Blood pressure_____
☐ Asthma _____	☐ Depression _____
☐ Diabetes _____	☐ Heart Disease _____
☐ Allergies _____	☐ Thyroid disease _____
☐ Seizures _____	☐ Stroke _____
☐ Alcoholism _____	☐ Kidney disease _____
☐ Arthritis	☐ Other _____

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1 Medical and Lifestyle Information

Date of last physical exam:_____ Weight _____ Height_____Weight 1 year ago _____

Date of last dental check up: _____ Do you have any mercury fillings? Y ☐ N ☐ If yes, how many? ____

Please circle the number that Indicates your level of stress
(0= no stress, 5= moderate stress, 10= extremely stressful)

Financial	0	1	2	3	4	5	6	7	8	9	10
Job Related	0	1	2	3	4	5	6	7	8	9	10
Relationship	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Family Members	0	1	2	3	4	5	6	7	8	9	10
Spiritual	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

List all your current prescription medications including dose and reason for taking?

_____

_____

How many times have you been treated with antibiotics in the last 5 years? _____

List all your over-the-counter medications that you take (for example: aspirin, Tums, Tylenol) and include dose and frequency:

_____

List all vitamins, minerals, herbs, Asian medicines, or homeopathic supplements you are taking and include dosage: _____

_____

Do you have any known allergies (environmental, medicines)? Y ☐ N ☐ If yes, what are they?

_____

Do you have any food allergies or intolerances? Please list.

_____

Do you get regular screening tests done by another doctor? Y ☐ N ☐
(Pap smear, breast, prostate, blood tests, etc.)

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Check off any of the following if they are a CURRENT or RECURRING symptom.

General

- ☐ Change in appetite
- ☐ Poor sleep
- ☐ Fatigue
- ☐ Chills
- ☐ Fevers
- ☐ Night sweats
- ☐ Sweat easily
- ☐ Sudden decrease in energy
- ☐ Cravings
- ☐ Strong thirst
- ☐ Weight gain
- ☐ Weight loss
- ☐ Peculiar tastes or smells
- ☐ Bleed or bruise easily

Skin and Hair

- ☐ Rashes
- ☐ Eczema
- ☐ Itching
- ☐ Pimples
- ☐ Change in hair or skin texture
- ☐ Loss of hair
- ☐ Dandruff
- ☐ Recent moles
- ☐ Dryness
- ☐ Ulcerations
- ☐ Skin Cancer

Head, Eyes, Ears, Nose, and Throat (HEENT)

- ☐ Headaches
- ☐ Head or neck problems
- ☐ Concussions
- ☐ Eye strain
- ☐ Glasses
- ☐ Night blindness
- ☐ Eye pain
- ☐ Color blindness
- ☐ Blurry vision
- ☐ Cataracts
- ☐ Earaches
- ☐ Poor hearing
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Teeth problems
- ☐ Jaw clicks
- ☐ Gums bleed easily
- ☐ Facial pain
- ☐ Recurrent sore throats
- ☐ Sores on lips, tongue or mouth

Respiratory

- ☐ Difficulty breathing
- ☐ Cough
- ☐ Bronchitis
- ☐ Asthma
- ☐ Pain with a deep breath
- ☐ Production of mucus
- ☐ Coughing blood
- ☐ Pneumonia
- ☐ Other

Cardiovascular

- ☐ High blood pressure
- ☐ Low blood pressure
- ☐ Irregular Heartbeat
- ☐ Dizziness
- ☐ Fainting
- ☐ Chest pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Cold hands or feet
- ☐ Swelling of hands
- ☐ Swelling of ankles/feet

Gastrointestinal

- ☐ Indigestion
- ☐ Gas
- ☐ Bad breath
- ☐ Constipation
- ☐ Abdominal pain or cramps
- ☐ Nausea
- ☐ Vomiting
- ☐ Laxative use
- ☐ Rectal pain
- ☐ Hemorrhoids
- ☐ Blood in stool
- ☐ Diarrhea

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Genito-urinary

- ☐ Frequent urination
- ☐ Urgency to urinate
- ☐ Pain on urination
- ☐ Wake at night to urinate
- ☐ Unable to hold urine
- ☐ Decrease in flow
- ☐ Blood in urine
- ☐ Kidney stones
- ☐ Impotency
- ☐ Sores on genitals
- ☐ Frequent urinary tract infections
- ☐ Other

Gynecology and Pregnancy

Are you pregnant? Y ☐ N ☐ What is the first day of your last period? _____

Age of first period_____How long does your period last?_____

Date of last PAP_____ Normal cells ☐ Abnormal cells ☐

- ☐ Regular periods
- ☐ Irregular periods
- ☐ Painful periods
- ☐ Vaginal discharge
- ☐ Vaginal sores
- ☐ Clots
- ☐ Changes in body or emotions prior to menstruation. Please describe. _____
- ☐ Heavy flow
- ☐ Light flow
- ☐ Live pregnancies #_____
- ☐ Miscarriage #_____
- ☐ Abortion #_____
- ☐ Birth control used. If yes, what type?_____
- How many years have you been on the birth control pill? _____

Musculoskeletal

- ☐ Neck pain
- ☐ Back pain
- ☐ Hand/wrist pain
- ☐ Shoulder pain
- ☐ Knee Pain
- ☐ Foot / ankle pain
- ☐ Hip Pain
- ☐ Other joint or bone problems?
- ☐ Muscle pain
- ☐ Muscle weakness

Neuropsychological

- ☐ Loss of balance
- ☐ Quick temper
- ☐ Poor memory
- ☐ Anxiety
- ☐ Depression
- ☐ Susceptible to stress
- ☐ Dizziness
- ☐ Lack of coordination
- ☐ Concussion
- ☐ Seizures
- ☐ Areas of numbness

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