Harbourfront
Health & Wellness Centre

Dr. Kerry Barlow, B.Sc. (Hons) N.D.
Doctor of Naturopathic Medicine

# Adult Intake Form

(Please Print Clearly)

Thank you in advance for taking the time to complete this intake form. We look forward to working with you in your naturopathic care. Please return this form to our clinic before your visit so that we can do an evaluation with the given information and also work on your treatment protocol while you await your appointment. If you are not able to drop it by before your first appointment, please bring it with you at your first visit.

**Today's Date**: ______________________

**First Name**: ________________________ **Last Name**: ______________________________
**Middle Name(s):** ____________________

**Date of Birth (D/M/Y):** ________________ **Age**: ____________ **Sex (circle one):** M / F

**Home Address**: _____________________ City: ___________________________________
____________________________________ Province: ________________________________
____________________________________ Postal Code: _____________________________

**E mail Address**: ______________________________________________________________

**Telephone Number**: Home:___________________________________
Work: ___________________________________
Mobile: _________________________________

**May we leave messages relating to your visits**: Home Y / N Work Y / N Mobile Y / N

**Emergency contact**: Name: _________________________________
Phone Number: ___________________________
Relation: _______________________________

**How did you hear about our clinic**: _______________________________________________

| **Relationship Status** (circle all that apply): | Married | Partner-ship | Separated | Divorced | Widowed | Single | Common Law |
|---|---|---|---|---|---|---|---|

**Occupation**: ________________________ Hours/wk: ___________ □ Retired

## Other Health Care Providers:

Have you been under the care of another Naturopathic Doctor before? Yes / No
If Yes, by whom? ______________________________ When (dates): _______________________

| Providers Name: | |
|---|---|
| Title (i.e. Family Physician, Chiropractor, Massage Therapist, etc…): | |
| Address: | |
| Phone: | Fax: |

| Providers Name: | |
|---|---|
| Title (i.e. Family Physician, Chiropractor, Massage Therapist, etc…): | |
| Address: | |
| Phone: | Fax: |

| Providers Name: | |
|---|---|
| Title (i.e. Family Physician, Chiropractor, Massage Therapist, etc…): | |
| Address: | |
| Phone: | Fax: |

Do you get regular screening tests done by any other doctor (PAP, blood tests, etc..)?
□ Yes □ No

If yes, by whom? ___________________________________________________________________

## Health Concerns:

**Naturopathic and preventative health care are greatly facilitated when the doctor has a complete picture of each client physically, mentally and emotionally. Please take the time to thoroughly complete this health history questionnaire.

| **Please list your health concerns in order of importance:** | |
|---|---|
| **1.** | **Health Concern:** |
| | Age this began/occurred: |
| | Related Events: |
| | Medications/Supplementations Used: |
| | What makes it better? Worse? |
| | Last Appointment: |

| | |
|---|---|
| **2.** | **Health Concern:** |
| | Age this began/occurred: |
| | Related Events: |
| | Medications/Supplementations Used: |
| | What makes it better? Worse? |
| | Last Appointment: |

| | |
|---|---|
| **3.** | **Health Concern:** |
| | Age this began/occurred: |
| | Related Events: |
| | Medications/Supplementations Used: |
| | What makes it better? Worse? |
| | Last Appointment: |

What is the main reason you are coming into our clinic today? ______________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How much change are you willing to make at this point in time for your health? _______________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

What do you enjoy most in your life (i.e. hobbies, family, etc…)? _____________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

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## Medical History:

| How would you describe your general state of health (please circle one): | Excellent | Good | Fair | Poor |
|---|---|---|---|---|
| If you circled anything but excellent, how long has it been since you experienced excellent health? ________ | | | | |
| Which (if any) of the following were used when you were delivered as a baby? | Prolonged labor | Forceps Delivery | Other (please specify): | |
| Were you breast fed as a baby? | Yes / No | If yes, how long? | | |

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

### Childhood Illnesses

Have you ever experienced any of the following illnesses (include approximate dates)?

- □ Rubella/German Measles
- □ Mumps
- □ Rubeola/Measles
- □ Chicken pox
- □ Whooping Cough/Pertussis
- □ Asthma
- □ Scarlet Fever
- □ Polio
- □ Rheumatic Fever
- □ Frequent ear infections
- □ Frequent colds
- □ Strep Throat
- □ Impetigo
- □ Mononucleosis
- □ Tonsillitis
- □ Diphtheria
- □ Other:________

### Immunizations

Please indicate which immunizations you have had (include approximate dates)

| | Dates: | | Dates: |
|---|---|---|---|
| □ DPT (diphtheria, pertussis, tetanus): | | □ Hepatitis B: | |
| □ Tetanus booster: | | □ Hepatitis A: | |
| □ MMR (Measles, Mumps, Rubella): | | □ Polio: | |
| □ Haemophilus influenza B: | | □ Flu: | |
| □ Chicken pox: | | □ Other: | |

□ I have never been immunized

Have you ever had an adverse reaction to immunizations? If yes please specify: ____________

________________________________________

________________________________________

### Hospitalizations, Surgeries, Imaging

Please list any hospitalizations, surgeries, x-rays, and other imaging scans that you have had

| **Procedure:** | **Date:** | **Procedure:** | **Year:** |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |

**Allergies / Sensitivities**

Please list all allergies, hypersensitivities, or intolerances:

| Medications | Foods | Environmental | Other |
|---|---|---|---|
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |
| | | | |

**Medications / Supplements**

Please list all current prescription, over the counter medications, vitamins, or other supplements you are taking and the reason you are taking them:

| Medication/Supplement/Vitamin/Mineral | Reason |
|---|---|
| | |
| | |
| | |
| | |

Please list all past prescription medications, the reason you were taking them and when you stopped taking them:

| Medication/Supplement/Vitamin/Mineral | Reason |
|---|---|
| | |
| | |
| | |
| | |

Do you frequently use any of the following?

| Substance | Indication (if applicable) | Amount per day or week |
|---|---|---|
| □ Aspirin | | |
| □ Laxatives | | |
| □ Diet Pills | | |
| □ Antacids | | |
| □ Alcohol | | |
| □ Tobacco | | |
| □ Caffeine (please indicate source i.e. coffee, tea, pop) | | |
| □ Recreational drugs (please specify type) | | |
| □ Refined food | | |
| □ Processed foods | | |

**Dietary Intake:**
Describe a typical day's diet?

| | |
|---|---|
| Breakfast | |
| Lunch | |
| Dinner | |
| Snacks | |
| Beverages (please include amount of water consumed daily and total quantities of all beverages consumed) | |

List any foods that you crave regardless of their nutritional value (include chocolate, sweets, salty, sour, bread, rich fatty foods): ________________________________________________

________________________________________________

________________________________________________

## Family Medical History:

**Please indicate which (if any) of your relatives have been affected by any of the following medical conditions:** Allergies, asthma, heart disease, high blood pressure, cancer (please specify type), diabetes, depression, other mental disease, drug abuse/alcoholism, kidney disease, seizures, stroke, other (please specify).

| Relative | Age (if alive) | Age at death (if deceased) | Ailment(s) |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Brothers | | | |
| Sisters | | | |
| Children | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Maternal Aunts/Uncles | | | |
| Paternal Aunts/Uncles | | | |

□ I don't know my family medical history

## Lifestyle and Environment:

Do you exercise regularly? Y / N
What do you do for exercise (how much, how often)? ________________________________

| | |
|---|---|
| Yes/No | 1. Has your doctor ever said you have heart trouble and that you should only do physical activity recommended by a doctor? |
| Yes/No | 2. Do you feel pain in your chest when you do physical exercise? |
| Yes/No | 3. In the past month, have you had chest pain at rest? |
| Yes/No | 4. Do you lose your balance because of dizziness or have you ever lost consciousness? |
| Yes/No | 5. Do you have a bone or joint problem that might be aggravated by a change in your physical activity? |
| Yes/No | 6. Is your doctor currently prescribing drugs (e.g. water pills) for your blood pressure or heart condition? |
| Yes/No | 7. Do you know of any other reason why you should not do physical activity? |

**Sleep**:

| | | |
|---|---|---|
| Do you have trouble falling asleep? | □ Yes | □ No |
| Do you have trouble staying asleep? | □ Yes | □ No |
| Do you dream? | □ Yes | □ No |

At what time of day is your energy the best? ______________ The worst? ______________

Do you make time for rest, relaxation or meditation during the day and/or before bed? How do you relax?________________________________________________________________

________________________________________________________________

Are you exposed to toxins (i.e. cigarette smoke) or other hazards (work, home, hobbies, etc…)? Please describe: ________________________________________________________

________________________________________________________________

How would you describe the emotional climate of your home? __________________________

________________________________________________________________

How stressful is your work or other aspects of your life? How do you manage stress? ________

________________________________________________________________

________________________________________________________________

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

________________________________________________________________

________________________________________________________________