Marda Loop Naturopathic and Wellness Clinic

Dr. Hillary, ND www.mardaloopwellness.com

ADULT INTAKE FORM

Thank you for taking the time to complete the following new patient forms. Given this form is extensive, it plays an integral role in achieving our mutual goal of your optimal health.

Name			Date
Birth Date d d / m m / y y y y	Age	Gender	Home #
Address			
City	Province		Postal Code
Phone number (preferred number used):		May we leave messages?	
Email Address:			
Occupation:			
Emergency Contact (Name and Relationship and Phone Number):			
Family Doctor – Name and Contact		Date of last physical: Date of last blood work:	
How did you hear about Dr. Hillary?			

Please state your most important health concerns/conditions (in descending order of importance, diagnosis made by whom, and date):

_____

_____

_____

_____

_____

What are your expectations for your visit to the clinic?

Have you tried other conventional or alternative treatments? If so, what were they and what were the results?

Please list past health problems with dates (include hospitalizations, surgeries, injuries and medical conditions):

Please list any medications and/or supplements you are currently taking (Include vitamins, herbs, natural products and pharmaceuticals as well as dosage and frequency:

Please list past medications and supplements and their purpose:

How many times have you been treated with antibiotics? _____

Are you sensitive or have allergies to any of the following (please specify):

Medications: _____

Foods: _____

Environment: _____

Which of the following illnesses and conditions have you had (past and present)? Please check all that apply:

SKIN HAIR AND NAILS
_____ Acne
_____ Psoriasis
_____ Warts (genital of facial)
_____ Eczema
_____ Roseola
_____ Chicken Pox

HEAD, EARS, EYES, NOSE, THROAT
_____ Migraines
_____ Headaches
_____ Mononucleosis
_____ Frequent Colds
_____ Ear Infections
_____ Eye Infections
_____ Strep Throat
_____ Hay Fever
_____ Sinusitis
_____ Tonsillitis
_____ Mumps
_____ Malaria

PELVIC ISSUES
_____ Sexually Transmitted Infections
_____ Candida (Yeast)
_____ Infertility

ENDOCRINE
_____ Diabetes
_____ Hypothyroidism
_____ Hyperthyroidism

MENTAL, EMOTIONAL, GENERAL
_____ Depression
_____ Anxiety
_____ Chronic Fatigue
_____ Multiple Sclerosis
_____ Schizophrenia
_____ Eating Disorder
_____ Lupus
_____ HIV
_____ Bipolar Disorder
_____ Epilepsy
_____ Hyperactivity
_____ Joint Pain

CARDIOVASCULAR AND RESPIRATION
_____ Difficulty Breathing
_____ Heart Disease
_____ Whooping Cough
_____ Tuberculosis
_____ High Blood Pressure
_____ Heart Palpitations
_____ Heart Murmur
_____ Frequent Coughs
_____ Shortness of Breath
_____ Pneumonia
_____ Croup
_____ Stroke
_____ Rheumatic Fever

GASTROINTESTINAL
_____ Bloating
_____ Gas
_____ Liver Disease
_____ Stomach or intestinal Ulcers
_____ Prostatitis
_____ Hepatitis
_____ Gall Stones
_____ Pancreatitis
_____ Diverticulitis
_____ Kidney Disease
_____ Kidney Stones
_____ Irritable Bowel Syndrome
_____ Constipation
_____ Chrons' Disease
_____ Acid Reflux
_____ Hernia
_____ Hemorrhoids

Have you travelled outside of Canada recently? YES NO Please list when and where:

_____

_____

Women's Health

Age of first menstrual period: _____ How long is your typical menstrual cycle? _____

When was your last menstrual period? _____

Please circle all that apply to you, in relation to your menstruation:

Heavy flow	Light flow	Clotting	Vaginal discharge
Vaginal dryness	Vaginal Itching	Vaginal Odor	Pain During intercourse
Abnormal Pap Test	Spotting between Periods	Breast Tenderness	Painful periods
Cramping	Cravings	Headaches	Bloating
Water retention	Irritability	Fatigue	Insomnia
Anxiety	Others: _____		

Are you pregnant? YES NO Any problems with fertility? YES NO Not sure

Number of pregnancies: _____ Number of miscarriages: _____

Number of births: _____ Number of abortions: _____

Birth control Method: _____

Birth control Method in the past (include how long used): _____

_____

Date of last pap test: _____ Was it normal? _____

Have you had a hysterectomy? YES NO

Do you perform self-breast examinations? YES NO

Do you receive regular mammograms? YES NO

Men's Health

Please circle all that apply to you:

Prostate Problems	Swelling/lumps in testicles	Painful erection
Discharge from penis	Infertility	Difficulty maintaining/achieving Erection
Premature ejaculation	painful/difficult urination	

Are you currently sexually active? YES NO

If yes, what type of contraception do you use? _____

Family History

Relation	Age	Medical Condition (or cause of death)
Father		
Mother		
Brother (s)		
Sister (s)		
Maternal GM		
Maternal GF		
Paternal GM		
Paternal GF		

Are there any medical conditions that run in the family? _____

_____

Lifestyle

Nutrition

Please describe a typical days diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Water intake: _____ Coffee/caffeine intake: _____ Alcohol intake (/day or /week): _____

Are their any foods that you crave? _____

Are you satisfied with your current diet? _____

Energy and Stress

Rate your energy level: Low 1 2 3 4 5 6 7 8 9 10 High

Rate your stress level: Low 1 2 3 4 5 6 7 8 9 10 High

What are your methods of dealing with stress? _____

_____

Do you exercise? YES NO If yes, what type and how often? _____

Do you use drugs? YES NO If yes, what type and how often?_____

Sleep Patterns

Do you have trouble falling asleep? YES NO

Do you sleep through the night? YES NO

Do you wake feeling refreshed? YES NO

Do you have recurring dreams or nightmares? YES NO If yes, what is the theme:

_____

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

Home Environment

Do you live close to any of the following? Circle any that apply.

Airport Dump Highway Industry Power lines

Have you done any major recent renovations to your home? YES NO If yes, explain:

_____

How old is your home? _____ How long have you lived there? _____

Do you have any household pets? _____

Mental/Emotional Information

Please share a little bit about yourself! A short description – personality, strengths, weaknesses, etc.

_____

_____

_____

_____

What do you love to do?

_____

_____

_____

_____

What do you really dislike doing?

_____

_____

Do you have any fears? Do they interfere with your everyday life?

Have you experienced any major grief or disappointments – past or present?

Any known sexual or physical abuse?

If you are sexually active, how would you describe your sex life? Are you dissatisfied with any aspect?

How would you describe the quality of your personal relationships?

If you were to change one thing about yourself, what would that be?

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

Thank you for taking the time to fill this out – I look forward to sitting down with you and exploring your health!