Marda Loop Naturopathic and Wellness Clinic

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ADULT NATUROPATHIC INTAKE FORM

This is a comprehensive and confidential intake form that greatly assists in the understanding of your physical, mental, and emotional health both past and present. This information is necessary to properly assess you as an individual and prepare an optimal treatment plan. Thank-you for taking the time to fill out this intake.

Registration Information

Name: _____ Today's Date: _____
(First) (Middle) (Last) dd / mm / yy

Date of Birth: ____/____/____ Age: _____ Gender: _____
dd / mm / yy

Home Address: _____

Town/ City: _____ Province:_____ Postal Code: _____

Preferred Phone Number: ( ) _____

May we leave messages on your home phone relating to your visits? □ Yes □ No

Would you like to receive e-mail reminders about your appointments? □ Yes □ No

Email Address: _____

Emergency contact: _____ Phone:( ) _____

Occupation: _____ Marital status:_____

How did you find out about our Naturopathic Services?
□ Referral - Whom may we thank? _____
□ Newspaper/ magazine / flyer
□ Internet search
□ Other _____

Family Physician: _____ Phone:( )_____

Date of last physical exam or blood work: _____

Other Health Care providers: _____
_____
_____
_____

Chief Health Concerns

What are your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____

List any other concerns you may want to discuss:
_____
_____
_____
_____
_____

Medical History

How would you describe your general state of health?
□ Excellent □ Good □ Average □ Fair □ Poor

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list with approximate dates:
_____
_____
_____
_____

Do you have any allergies (medicines, environmental, foods)?
_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:
_____
_____
_____

Approximately how many times have you been treated with antibiotics?

_____

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

_____
_____
_____
_____

Which of the following illnesses and conditions have you had (past or present)?

- ☐ Acne
- ☐ Alcoholism
- ☐ Arthritis
- ☐ Asthma
- ☐ Bipolar disorder
- ☐ Cancer
- ☐ Candida (yeast)
- ☐ Chest pain
- ☐ Chicken pox
- ☐ Chronic Fatigue Syndrome
- ☐ Colitis
- ☐ Constipation
- ☐ Crohn's disease
- ☐ Cushing's disease
- ☐ Depression
- ☐ Diabetes
- ☐ Diverticulitis
- ☐ Eating disorder
- ☐ Eczema
- ☐ Epilepsy
- ☐ Gall stones
- ☐ Gonorrhea
- ☐ Gout
- ☐ Hay fever
- ☐ Heart disease
- ☐ Heart problems
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ Hernia
- ☐ Herpes
- ☐ High blood pressure
- ☐ HIV
- ☐ Hypothyroidism
- ☐ Hyperthyroidism (thyroiditis)
- ☐ Infertility
- ☐ Irritable Bowel Syndrome
- ☐ Kidney disease
- ☐ Lupus
- ☐ Malaria
- ☐ Migraines
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ MS
- ☐ Mumps
- ☐ Osteoporosis
- ☐ Peritonitis
- ☐ Prostatitis
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Scarlet fever
- ☐ Schizophrenia
- ☐ Sexually Transmitted Infection
- ☐ Shingles
- ☐ Sinusitis
- ☐ Skin disease
- ☐ Stroke
- ☐ Substance Use disorder
- ☐ Tuberculosis
- ☐ Ulcers
- ☐ Warts
- ☐ Wilson's disease

Are you up to date with your immunizations? ☐ Yes ☐ No

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)

_____
_____

Family Health History

Indicate if a close relative (parent, grandparent, sibling) has, or has had any of the following:

☐ Allergies	☐ Endometriosis	☐ Osteoporosis
☐ Artificial Heart Valve	☐ Gallstones	☐ PMS
☐ Arthritis	☐ Heart Disease	☐ Rubella
☐ Asthma	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Cancer (type_____)	☐ Kidney Disease	☐ Skin Disease
☐ Diabetes	☐ Mental Illness	☐ Stroke
☐ Eczema	☐ Multiple Sclerosis	☐ Tuberculosis

Any other medical conditions that run in your family?

_____
_____
_____

Personal Health

Do you have food allergies or intolerance's? Please list:

_____
_____
_____

Do you have any dietary restrictions (religious, vegetarian/ vegan, etc.)?

_____
_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (total amount) _____

Current weight: _____lbs
Weight one year ago: _____lbs
Max weight: _____lbs
Height: _____

Rate your energy level:

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Rate your stress level:

☐ Excellent ☐ Good ☐ Average ☐ Fair ☐ Poor

Do you exercise regularly? □ Yes □ No

What type of exercise, how much, how often? _____
_____
_____

Do you frequently use any of the following?
□ Laxatives □ Antacids
□ Diet pills □ Aspirin/Tylenol/Advil
□ Caffeine - form and amount/day _____
□ Alcohol - how much/day or week _____
□ Tobacco - how much/day or week _____
□ Recreational drugs - what and how often _____
_____

Do you sleep well? □ Yes □ No Do you fall asleep easily? □ Yes □ No
Average amount of sleep? _____ Do you wake rested? □ Yes □ No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:
_____
_____

Women's Health

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

Do you experience any of the following?
□ Heavy flow
□ Clotting
□ Light flow
□ PMS
□ Vaginal discharge
□ Pain during intercourse
□ Vaginal itching
□ Vaginal Odour
□ Vaginal dryness
□ Abnormal Pap test
□ Bleeding between periods
□ Breast tenderness

If you checked PMS, which apply?
□ Pain
□ Cramping
□ Cravings
□ Mood swings
□ Headaches
□ Bloating
□ Water retention
□ Breast tenderness
□ Irritability
□ Fatigue
□ Insomnia
□ Anxiety
Others:_____
_____
_____

Are you currently sexually active? □ Yes □ No
Have you ever used (or are you currently using) birth control? □ Yes □ No
Type and duration of use: _____
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 _____
Date of last Pap test: _____
Was it normal? □ Yes □ No
Have you had a hysterectomy? □ Yes □ No
Do you perform monthly self breast examinations? □ Yes □ No
When was your last breast exam? _____
Do you receive regular mammograms? □ Yes □ No

Men's Health

Please check any past or present health concerns:

□ Prostate problems
□ Swelling/lumps in testicles
□ Painful erection
□ Discharge from penis
□ Infertility
□ Difficulty maintaining/achieving erection
□ Difficulty/premature ejaculation
□ Painful/difficult urination

Are you currently sexually active? □ Yes □ No
If yes, what type of contraception do you use? _____

Dental Health

Last dental check-up: Last cleaning: _____
Were your wisdom teeth removed? □ Yes □ No
Any fillings? □ Yes □ No Type? (ie. mercury, ceramic) _____
Any trauma to the teeth or jaw? □ Yes □ No Location? _____
Are your teeth hot or cold sensitive? □ Yes □ No
Any orthodontic work done (ie. Braces)? □ Yes □ No Type?_____

Mental Emotional Health

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

_____
_____
_____
_____

What do you LOVE to do?

Have you experienced any major grief or disappointment in the past? If you're comfortable, please describe.

Have you experienced any abuse in the past, physical or sexual? If you're comfortable, please describe.

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?

Are you an active participant in a religion? If so, which religion and how important is this to your life?

Is there anything that you feel that is important that hasn't been covered?

Thank-you for taking the time to complete this intake form! The answers you provide allow me to have a better understanding of who you are and what your main goals and health concerns are. Please fax, mail, or scan to email this form to the **Marda Loop Naturopathic and Wellness Clinic at least 48 hours before your appointment** to ensure I have time to go over what you have written. If sending a copy via e-mail use the addresses are as follows: ***patientcare@mardaloopwellness.com.***