Marda Loop Naturopathic and Wellness Clinic

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ADULT PATIENT INTAKE FORM

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(Previously Dr. Sarah Berrett, BSc, ND)

Patient information contained within this form is considered strictly confidential. Your responses are important to help us better understand the health issues you face and ensure the delivery of the best possible care.

Today's Date:

Name:	*First*	*Middle*	*Last*
Address:	*Street*		
	City	*Province*	*Postal Code*
Phone:	*Home*	*Work*	*Cell*
Email:			
Emergency Contact:	*Name*	*Relationship*	*Phone*
Date of Birth:	*MM/DD/YYYY*		
Gender:	*M F*		
Occupation:			
Employer:			
Marital Status:	*S M D W Sep*		
Insurance:			
Medical Doctor:	*Name*	*Phone*	*Last physical: DD/MM/YY* *Last Blood work: MM/YY*
Dentist:	*Name*	*Phone*	*Last check-up: DD/MM/YY*
Would you like to receive:	Email appointment reminders? Yes / No		
How did you hear about us?			

Please give a brief, detailed description of the problem(s) you are currently experiencing, in descending order of importance, with the date of diagnosis if applicable:

What seemed to be the initial cause (s) of your concerns?

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

Are you currently receiving any other treatments? If so, please list the practitioner and type of treatment.

What are your expectations for coming to our clinic?

Name ______________________

MEDICAL HISTORY

Please mark (c) for current problems or (p) for significant problems in the past:

Eyes
- ☐ Cataracts
- ☐ Colour blindness
- ☐ Eye pain
- ☐ Glasses or contacts
- ☐ Glaucoma

Ears
- ☐ Dizziness
- ☐ Ear ache
- ☐ Impaired hearing
- ☐ Ringing in the ears

Nose
- ☐ Loss of smell
- ☐ Nasal congestion
- ☐ Nosebleeds
- ☐ Sinus infections

Throat
- ☐ Frequent colds
- ☐ Hoarseness
- ☐ Sore throat (chronic)
- ☐ Tonsillitis

Respiratory
- ☐ Chronic cough
- ☐ Hay fever (or seasonal allergies)
- ☐ Shortness of breath
- ☐ Coughing up phlegm/blood
- ☐ Wheezing

Cardiovascular
- ☐ High blood pressure
- ☐ Chest pain
- ☐ Deep leg pain
- ☐ Easy bruising
- ☐ Fainting
- ☐ Irregular pulse
- ☐ Palpitations
- ☐ Poor circulation
- ☐ Rapid heartbeat
- ☐ Slow heartbeat
- ☐ Slow wound healing
- ☐ Swelling of the ankles

Endocrine
- ☐ Excessive hunger
- ☐ Excessive thirst
- ☐ Fatigue
- ☐ Heat/cold intolerance
- ☐ Hypoglycemia
- ☐ Hypothyroid
- ☐ Diabetes/hyperglycemia

Gastrointestinal
- ☐ Abdominal pain/bloating
- ☐ Bloody or black stools
- ☐ Colitis/Crohn's
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Poor appetite
- ☐ Excessive gas
- ☐ Gallbladder trouble
- ☐ Heartburn/reflux
- ☐ Hemorrhoids
- ☐ Hernia
- ☐ Intestinal worms
- ☐ Jaundice (yellow skin)
- ☐ Liver trouble
- ☐ Nausea/ vomiting
- ☐ Painful bowel movements

Genitourinary
- ☐ Bed-wetting
- ☐ Bladder infection
- ☐ Genital lesions/discharge
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Sexual difficulty
- ☐ Sexually transmitted infection

Urination
- ☐ Overnight more than 2x
- ☐ More than 8x in 24hrs
- ☐ Blood in urine
- ☐ Incontinence
- ☐ Painful urination
- ☐ Urgent urination

Female
- ☐ Bleeding between cycles
- ☐ Breast pain/distension
- ☐ Endometriosis
- ☐ Hot flashes
- ☐ Lumps in breasts
- ☐ Menopause
- ☐ Nipple discharge
- ☐ Ovarian cysts
- ☐ PMS
- ☐ Vaginal discharge
- ☐ Vaginal dryness

Menstrual flow
- ☐ Heavy/Light (circle)
- ☐ Pain/Cramps
- ☐ Excessive bleeding
- ☐ Clotting
- ☐ Days of flow:______
- ☐ Length of cycle:________
- ☐ Age of first menses:_________
- ☐ First day of last period: ____________________
- ☐ Number of pregnancies:______
- ☐ Are you pregnant? Yes/no
  If yes, how many months: ____
- ☐ Number of miscarriages: _____
- ☐ Number of births:__________
- ☐ Number of abortions:________
- ☐ Are you sexual active? Yes No
- ☐ Birth control method: ____________________
- ☐ Birth control used in the past (for how long?)____________ ____________________
- ☐ Date of last PAP test: ____________________
  Normal / Abnormal (circle)
- ☐ Date of last mammogram: ____________________
  Normal / Abnormal (circle)
- ☐ Do you perform self-breast examinations? Yes No

Male
- ☐ Prostate problems
- ☐ Swelling/lumps in testicles
- ☐ Penile discharge
- ☐ Infertility
- ☐ Difficulty achieving or maintaining an erection
- ☐ Painful erection
- ☐ Premature ejaculation
- ☐ Painful/difficult urination
- ☐ Currently sexually active
  If yes, birth control_________

Mental-emotional
- ☐ Anger
- ☐ Anxiety
- ☐ Depression
- ☐ Insomnia
- ☐ Irritability
- ☐ Excessive sleeping
- ☐ Memory loss
- ☐ Mental disorder
- ☐ Nervousness
- ☐ Nightmares
- ☐ Suicidal thoughts
- ☐ Teeth clenching/grinding

Muscle/Joint/Pain
- ☐ Arthritis/Rheumatism
- ☐ Back/neck pain
- ☐ Broken bone
- ☐ Bursitis
- ☐ Concussion/head injury
- ☐ Foot trouble
- ☐ Headaches
- ☐ Joint pain
- ☐ Muscle weakness
- ☐ Migraines
- ☐ Numbness/tingling
- ☐ Sciatica
- ☐ Sprain/strain
- ☐ Tremors

Skin
- ☐ Acne/boils
- ☐ Dryness
- ☐ Easy bruising
- ☐ Eczema or hives
- ☐ Itching
- ☐ Hair loss
- ☐ Rash
- ☐ Varicose veins

Check any conditions you have or have had:
- ☐ Alcoholism
- ☐ Alzheimer's/dementia
- ☐ Anemia
- ☐ Appendicitis
- ☐ Arteriosclerosis
- ☐ Asthma
- ☐ Autoimmune disease
- ☐ Bronchitis
- ☐ Cancer
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Goiter
- ☐ Gout
- ☐ Heart disease
- ☐ Hepatitis
- ☐ Herpes
- ☐ High cholesterol
- ☐ HIV/AIDS
- ☐ Malaria
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Pacemaker
- ☐ Osteoporosis
- ☐ Pneumonia
- ☐ Polio
- ☐ Rheumatic fever
- ☐ Stroke
- ☐ Thyroid disease
- ☐ Tuberculosis

Have you…
- ☐ Been hospitalized in the last 5yr
- ☐ Had any recent surgeries
  If yes, explain: ____________ ____________________

Name ____________________

FAMILY MEDICAL HISTORY

Relation	Age	Living/Dead (L/D)	Medical Condition (s) or cause of death
Father			
Mother			
Brother (s)			
Sister (s)			
Maternal GM			
Maternal GF			
Paternal GM			
Paternal GF			
Other			

Are there any other medical conditions that run in the family? ____________________

____

ALLERGIES

Please list any allergies to medications: ____________________
Please list any environmental allergies: ____________________
Please list any known food allergies: ____________________
Please list any other allergies: ____________________

MEDICATIONS

Please list your medications below in as much detail as possible and bring your bottles with you to your appointment:

Drug	Dosage	Start Date	Reason

Please list past medications and their purpose____________________
How many times have you taken antibiotics?__________

SUPPLEMENTS

Please list any supplements you are currently taking along with brand and dosing:

____
____
____

VACCINATIONS

- ☐ Did you receive the normal vaccine schedule as a child Yes/No
- ☐ Any additional vaccines____________________
- ☐ Any reactions to vaccines____________________
- ☐ Have you traveled outside Canada recently? If so, where?____________________

LIFESTYLE

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 smoke? Yes No In the past If yes, for how long?__________ Packs per day:__________
Do you do any recreational drugs? Yes No

How often do you drink alcohol? ______________________

Do your drink coffee? Yes No If yes, how much?______________________

Do you watch TV? Yes No If yes, how much?______________________

Sleep:

Do you have trouble falling asleep? Yes No

Do you sleep through the night? Yes No

Do you wake feeling refreshed? Yes No

How many hours of sleep do you normally get?______________________

Home Environment

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

Airport Dump Highway Industry Power Lines Cell Phone Tower

Have you done any major renovations in your home recently? Yes No

How old is your home? ____________ How long have you lived in your current home?____________

Do you have any household pets? ______________________

Have you ever been exposed to any toxic chemicals or heavy metals? Yes No If yes, describe:______________________

DIET

Do you have any known food intolerances or allergies? If so, please list.______________________

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

How many meals do you generally eat each day?______________________

Do you drink soft drinks? Yes No If yes, how often?______________________

Describe a typical day's diet:

Breakfast______________________

Snack______________________

Lunch______________________

Snack______________________

Dinner______________________

Snack______________________

Beverages______________________

How much water do you drink in a day? ______________________

Height:____________ Weight:____________ Weight 1 year ago:____________

CONTEXT OF CARE

Please answer the following to the best of your ability.

1. What long-term goals do you have from working with me as your doctor?

   a)______________________

   b)______________________

2. What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 1 to 10, 10 being 100% committed) 1 2 3 4 5 6 7 8 9 10

3. What do you LOVE to do?

   ____

   ____

   ____

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

   ____

   ____

   ____

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

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

7. How would you describe the quality of your personal relationships?

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

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

Thank you for taking the time to complete this intake form. The answers you provide allow us 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 the Doctor has time to go over what you have written. If sending a copy via e-please send to: patientcare@mardaloopwellness.com.