

# NATUROPATHIC PERSPECTIVES

*Redefining Your Health*



## Adult Intake Form

Name \_\_\_\_\_ Today's Date \_\_\_\_\_

Date of birth \_\_\_\_\_ (M/D/Y) Sex M / F

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E-mail Address: \_\_\_\_\_

Telephone numbers: Home: \_\_\_\_\_

Work: \_\_\_\_\_

May we leave messages relating to your visits? Yes / No

### *Emergency contact:*

Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about our Clinic: \_\_\_\_\_

Referred by: \_\_\_\_\_

### *Other health care providers (i.e. Medical Doctor, Pediatrician, Chiropractor) you are seeing:*

1. \_\_\_\_\_ 2. \_\_\_\_\_ 3. \_\_\_\_\_

\_\_\_\_\_  
\_\_\_\_\_

(\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_ (\_\_\_\_) \_\_\_\_\_

What are your health concerns, in order of importance to you:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

If you are female are you currently pregnant? Yes / No (Please circle one)

**Medical history**

How would you describe your general state of health? (please circle)

Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations, along with approximate dates.

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Do you have any allergies (medicines, environmental, etc.)?

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Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

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Please list past prescription medications.

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How many times have you been treated with antibiotics? \_\_\_\_\_

Do you frequently use any of the following? (please circle)

Aspirin/Laxatives/Antacids/Diet pills/Birth control pills/implants/injections

Alcohol—how much/day or week \_\_\_\_\_

Tobacco—form and amount/day \_\_\_\_\_

Caffeine—form and amount/day \_\_\_\_\_

Recreational drugs—what and how often \_\_\_\_\_

Please indicate what immunizations you have had

DPT (diphtheria, pertussis, tetanus)     Haemophilus influenza B     Hepatitis A

Tetanus booster; when? \_\_\_\_\_     "Flu"     Hepatitis B

MMR (measles, mumps, rubella)     Polio     Smallpox

Other \_\_\_\_\_

Please indicate if any of the above vaccinations caused adverse reactions:

\_\_\_\_\_

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

Yes / No \_\_\_\_\_

\_\_\_\_\_

### **Nutritional History**

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

\_\_\_\_\_

\_\_\_\_\_

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

\_\_\_\_\_

\_\_\_\_\_

Describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages (and total quantity) \_\_\_\_\_

## **Family history**

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

	Who?		Who?
Allergies		Depression	
Asthma		Kidney disease	
Heart disease		Drug abuse or Alcoholism	
High blood pressure		Other mental illness	
Cancer		Other	
Diabetes			

I don't know my family medical history

## **Social Patterns**

Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Do you exercise regularly? Yes / No

What do you do for exercise, how much, how often?

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## **Environment**

Are you exposed to significant tobacco smoke (work, home, etc.)? Yes / No

Are you frequently exposed to animals (work, pets, etc.)? Yes / No

How is your home heated? \_\_\_\_\_

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

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How would you describe the emotional climate of your home?

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How stressful is your work, or other aspects of your life? How well do you handle these stresses?

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

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To the best of my knowledge, the information contained in this document is accurate.

Printed Name \_\_\_\_\_ Date \_\_\_\_\_

Signature \_\_\_\_\_