



### Adult Intake Form

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Name: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 City: \_\_\_\_\_ Postal Code: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Phone: \_\_\_\_\_  
 Age: \_\_\_\_\_ Date of Birth (MM/DD/YY): \_\_\_\_\_ Sex: \_\_\_\_\_  
 Email: \_\_\_\_\_

How did you hear about us? \_\_\_\_\_

#### Primary Health Concerns:

Please list in order of importance to you.

1. \_\_\_\_\_ 2. \_\_\_\_\_  
 3. \_\_\_\_\_ 4. \_\_\_\_\_  
 5. \_\_\_\_\_ 6. \_\_\_\_\_

Are there any traumatic events (surgeries, drug reactions, life trauma) that you feel may have caused or contributed to your health problems?

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

Please list all former treatments that you have used, both conventional and alternative, and the degree of effectiveness of each treatment.

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

If female, are you currently pregnant? Yes  No

#### Medical History

Which childhood illnesses have you had?

<input type="checkbox"/> Rubella (German Measles – 3 day)	<input type="checkbox"/> Measles (2 week)	<input type="checkbox"/> Mumps
<input type="checkbox"/> Chicken Pox	<input type="checkbox"/> Whooping Cough	<input type="checkbox"/> Polio
<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Scarlet Fever	<input type="checkbox"/> Roseola
<input type="checkbox"/> Asthma	<input type="checkbox"/> Other	

	Now	Past	Never		Now	Past	Never
Anemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Headache	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Allergies	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Heart murmur	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Alcohol abuse	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hyperthyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Asthma	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypoglycemia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Bleeding	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Hypothyroid	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Cancer	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Kidney disease	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Candida	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Liver dz/Jaundice	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Overweight	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Drug use	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Rheumatism	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Eczema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Tuberculosis	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**Medications/Supplements:**

Please list all of your present medications including drugs, supplements, homeopathics and herbs along with dosages. Include a separate page if needed.

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Please list all past prescription medications.

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How many times have you been treated with antibiotics? If number unknown, few/some/many

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Do you have any allergies (drug, other substances, environmental)?

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What symptoms do you experience with an allergy attack?

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Check off any of the following types of allergy testing that you have had:

Intradermal	<input type="checkbox"/>	Scratch	<input type="checkbox"/>	Blood IgG food	<input type="checkbox"/>
Food intolerance testing	<input type="checkbox"/>	Kinesiology	<input type="checkbox"/>	Blood IgE inhalant/food	<input type="checkbox"/>

Do you frequently use any of the following?

Aspirin	<input type="checkbox"/>	Laxatives	<input type="checkbox"/>
Diet pills	<input type="checkbox"/>	Antacids	<input type="checkbox"/>
Alcohol	<input type="checkbox"/>		
Tobacco	<input type="checkbox"/>		
Caffeine	<input type="checkbox"/>		
Recreational drugs	<input type="checkbox"/>		

**Immunizations:**

Please indicate what immunizations you have had and approximate year.

DPT (diphtheria, pertussis, tetanus)	<input type="checkbox"/>	Haemophilus influenza	<input type="checkbox"/>
Hepatitis A	<input type="checkbox"/>	Hepatitis B	<input type="checkbox"/>
MMR (measles, mumps, rubella)	<input type="checkbox"/>	Smallpox	<input type="checkbox"/>
Polio	<input type="checkbox"/>	Tetanus booster	<input type="checkbox"/>
Flu	<input type="checkbox"/>	Other _____	<input type="checkbox"/>

Please indicate if any caused adverse reactions:

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

Yes  No

**Family History:**

Please list ages and if deceased, what they died from and at what age.

**Mother's side**

Mother \_\_\_\_\_  
 Grandfather \_\_\_\_\_  
 Grandmother \_\_\_\_\_  
 Your sisters \_\_\_\_\_

**Father's side**

Father \_\_\_\_\_  
 Grandfather \_\_\_\_\_  
 Grandmother \_\_\_\_\_  
 Your brothers \_\_\_\_\_

Please indicate if a close relative has had any of the following:

Condition	Who?	Condition	Who?
Allergies		Hay fever	
Anemia		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Bleeding		Seizure/epilepsy	
Cancer		Sickle cell anemia	
Diabetes		Stroke	
Depression		Thyroid (hyper/hypo)	
Drug/alcohol abuse		Tuberculosis	
Eczema		Venereal disease (std)	
Glaucoma		Other	
Gout			

**Social History:**

Occupation:

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Do you enjoy your work? Or, is it a job that you feel you must do in order to make a living?

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Are you currently:      Single  With a partner       Number of children: \_\_\_\_\_

How would you describe your family relationships?

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Do you exercise regularly?      Yes       No

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

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What are your hobbies?

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How often do you drink: Wine: \_\_\_\_\_ Beer: \_\_\_\_\_ Other alcohol: \_\_\_\_\_

Do you use tobacco or have you in the past?      Yes       No

Years since quitting: \_\_\_\_\_

Are you exposed to significant tobacco smoke (work, home etc.)? \_\_\_\_\_

Do you now or have you in the past used marijuana or other drugs?      Yes       No

If yes, which drugs, how often and how long? \_\_\_\_\_

As far as you know, have been exposed to toxic chemicals, solvents or other possible toxins?

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

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How would you describe the emotional climate of your home? \_\_\_\_\_

How stressful is your work or other aspects of your life? How do you cope with or manage this?

**Sleep:**

Do you have trouble falling asleep? Yes  No   
Do you have trouble staying asleep? Yes  No

**Home environment:**

Are your home and work environments well-ventilated? Yes  No   
Are your home and work environments excessively Moist  Dry

**Diet:**

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

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

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How many meals do you generally eat each day? \_\_\_\_\_

Where do you usually buy your food? \_\_\_\_\_

**Describe a typical day's diet:**

Breakfast \_\_\_\_\_  
Snack \_\_\_\_\_  
Lunch \_\_\_\_\_  
Snack \_\_\_\_\_  
Dinner \_\_\_\_\_  
Snack \_\_\_\_\_  
Beverages (and total quantity) \_\_\_\_\_

Do you regularly consume any of the following (include approximate amount)?

Coffee  \_\_\_\_\_  
Caffeinated teas  \_\_\_\_\_  
Processed foods  \_\_\_\_\_  
Refined foods  \_\_\_\_\_  
Other food that you suspect may be harmful to your health \_\_\_\_\_

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

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Are you thirsty? Yes  No

Amount of water you drink each day \_\_\_\_\_

Are you satisfied with your diet the way it is now? Why or why not?

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Please mark next to the following symptoms that apply to you now or in the past.

Now	Past	Skin	Now	Past	Skin
		Dry, rough scaly, itchy skin			Pimples
		Rashes, warts			Loss of hair
		Moles, cysts			Hives
		Any of above change size/color			Scars
		Light/dark patches of skin			Color changes, ridges, pits, white spots on nails?

Now	Past	Lymphatic, Immune system	Now	Past	Endocrine
		Painful lymph nodes			Unexplained weight loss/gain
		Difficulty stopping bleeding			Prefers hot weather
		Bleeding from unusual places			Prefers cold weather
		Bruising easily			Can't stand cold
		Wounds heal slowly			Can't stand heat
		Anemia			Cold hands and feet
		Swollen glands			Fatigue- long term
		Fluid retention			Weakness
		Date of last blood tests			Increased thirst
					Increased hunger

Now	Past	Head	Now	Past	Ears
		Dizziness			Discharge from ears
		Severe headaches			Hearing problems
		Seizures, Convulsions			Sensitivity to noise
		Double vision			Pain in ears
		Fainting spells			Ringing in ears

Now	Past	Eyes	Now	Past	Nose
		Poor eyesight (near or far)			Nose bleeds
		Light hurts eyes			Sinus congestion
		Date of last glaucoma check			Nasal scabs/crusts

Now	Past	Mouth	Now	Past	Throat
		Sore mouth or throat			Persistent hoarseness
		Speech difficulties			Difficulty swallowing
		Bleeding gums			Recurrent strep throat
		Loss of teeth			Loss of voice
		Cold sores, blisters			Chronic sore throat or pain
		# of mercury amalgams			

Now	Past	Respiratory	Now	Past	Cardiovascular
		Unexplained fever			Chest pain when walking
		Chest pain when breathing			Chest pain when sitting/lying
		Wheezing			Ankle or abdominal swelling
		Difficulty breathing at night			Heart palpitations
		Chest congestion			Leg vein problems
		Dry sweats			Leg pain when walking
		Night sweats			Numbness/tingling in arm/leg
		Shortness of breath			Heart murmur
		Daily cough			

Have you ever been exposed to tuberculosis? \_\_\_\_\_

Have you ever had rheumatic fever or syphilis? \_\_\_\_\_

How far can you comfortably walk? \_\_\_\_\_

Do you get out of breath when climbing stairs? \_\_\_\_\_

Now	Past	Male Reproductive	Now	Past	Male Reproductive
		Prostate problems			Painful erection
		Swelling/lumps/pain in testicles			Difficulty with erection
		Discharge from penis			Premature ejaculation
		infertility			Difficulty with ejaculation

Date of last prostate exam \_\_\_\_\_

Are you currently sexually active? \_\_\_\_\_

What type of contraception do you use? \_\_\_\_\_

Now	Past	Gastrointestinal	Now	Past	Gastrointestinal
		Constipation			Distress from fat/greasy food
		Diarrhea			Bad breath
		Alternating const/diarrhea			Body odor
		Change in bowel movements			Indigestion immed after meal
		Strain at stool			Bloating 2 – 3 hrs after meal
		Hemorrhoids			Pain 5 – 6 hrs after eating
		Black stool			Above symptoms worse stress
		Blood in stool			Heavy, full after eating
		Stool – yellow, grey, green			Nervous/shaky, better w sweets
		Stool – foul odor			Cravings sweets or alcohol
		Stool – undigested food			Irritable if miss meal
		# of bowel movements			Appetite change inc/decrease
		Vomiting blood			Loss of appetite
		Frequent or severe nausea			Insatiable appetite
		Heartburn			Weight change – inc/decrease
		Trouble swallowing			Diet but fail to lose weight
		Excessive belching			Eat but fail to gain weight
		Excessive lower bowel gas			Overweight
		Difficulty belching			Underweight
		Stomach cramps, colic			Compulsive eating
		Abdominal bloat/ distension			Addictive eating
		Anorexia			Yellowjaundice
		Bulimia			Bad taste in mouth
		Stomach/abdominal pain			Intestinal parasites suspected

Now	Past	Female Reproductive	Now	Past	Female Reproductive
		Lumps in breast			Bleed/spot between periods
		Nipple discharge			Painful sex
		Breast pain			Lack of sexual desire
		Pelvic pain			Difficulty feeling sex. aroused
		Discharge from vagina			Never/seldom have orgasms
		Vaginal itching/burning			Menstruation excessive
		Genital eruptions			Menstruation absent

Do you perform regular breast self examinations? \_\_\_\_\_

Date of last mammogram: \_\_\_\_\_

Are you sexually active? \_\_\_\_\_

Type of contraception used? \_\_\_\_\_

Have you ever used birth control pills? \_\_\_\_\_

Did you experience any side effects? \_\_\_\_\_

Age of first menstruation \_\_\_\_\_ Did you have a normal puberty? \_\_\_\_\_

Is your cycle regular? Yes  No

Periods occur every \_\_\_\_\_ days and usually last \_\_\_\_\_ days.

Date of last period: \_\_\_\_\_

Date of last pap smear: \_\_\_\_\_ Was it normal? Yes  No

Have you ever had any problems with infertility? \_\_\_\_\_

# of pregnancies: \_\_\_\_\_ # of births: \_\_\_\_\_ # of miscarriages: \_\_\_\_\_ # of abortions: \_\_\_\_\_

Have you ever had any pregnancy complications? \_\_\_\_\_

Now	Past	Pituitary	Now	Past	Pituitary
		Failing memory			Low blood pressure
		Increased sexual desire			Decreased sexual desire
		Splitting headaches			Menstrual disorders
		High/low sugar tolerance			Intestinal bloating
		Abnormal thirst			Chunky hips or waist
		Ulcers, colitis			

Now	Past	Thyroid	Now	Past	Thyroid
		Overweight			Decreased appetite
		Difficulty losing weight			Nervousness
		Constipation			Heart palpitations
		Tired upon rising			Irritable/restless
		Easily fatigued			Increased appetite
		Dry or scaly skin			Underweight
		Chilly/sensitive to cold			Flush/get hot easily
		Mental slowness			Insomnia



Now	Past	Adrenals	Now	Past	Adrenals
		Easily stressed			Nails weak, ridged
		Easily/chronically fatigued			Tendency to get hives
		Dizziness			Rheumatism/arthritis
		Headaches			Poor circulation
		Hot flashes			Increased blood pressure
		Bronzing of the skin			Weak after getting a cold
		Craves salt			Facial hair for women

Now	Past	Sympathetic nervous system	Now	Past	Sympathetic nervous system
		Upset from acid foods			Cold extremities
		Dry eyes, nose, mouth			Light sensitive
		Nervousness			Decreased urine output
		Wounds that heal slowly			Heart pounds when lying
		Gag easily			Reduced appetite
		Very quick mentally			Frequent cold sweats

Now	Past	Parasympathetic nervous syst	Now	Past	Parasympathetic nervous syst
		Joint stiffness on rising			Frequent vomiting
		Muscle/leg/toe cramps			Alt. constipation/diarrhea
		Butterflies in stomach			Pulse slow/regular
		Digestion rapid			Breathing irregular
		Indigestion after eating			Poor circulation
		Perspiration scant/absent			Eyelids swollen/puffy
		Perspire easily/profusely			

Now	Past	Central/peripheral nerv. syst	Now	Past	Central/peripheral nerv. syst
		Loss of balance/fainting			Paralysis
		Dizziness regularly			Numbness/tingling
		Convulsions (seizures)			Temporary loss of sensation
		Blurred/double vision			Lack of strength
		Tremor (shaking, trembling)			Continual headache

Now	Past	Musculoskeletal system	Now	Past	Musculoskeletal system
		One arm or leg shorter			Muscle cramps
		Joint pain/stiffness swelling			Unusual redness of palms
		Backaches			Coughing, sneezing or straining at stools intensifies back pain
		Burning on soles of feet			

Now	Past	Mental status	Now	Past	Mental status
		Anxiety			Memory difficulties
		Restlessness			Mental confusion
		Excessive worry			Concentration difficulties
		Depression			Make a lot of errors
		Despair/discontent			Shy and timid
		Suicidal thoughts			Self-critical
		Suicidal attempts			Overly critical of others
		Loneliness			Lack of self-confidence
		Mood swings			Jealous and suspicious
		Prefer to be with people			Sensitive to noises
		Like to be alone			Organized and very neat
		Afraid when alone			Affectionate
		Confident and secure			Powerful and assertive

Please write a short description of how you see yourself:

Is there anything else that you believe is important for me to know about you?

**CARE REVIEW QUESTIONS**

- 1) a) Why did you choose this health care practitioner?  
  
b) What do you know about our approach?
  
- 2) a) What expectations do you have from your sessions?  
  
b) What long term expectations do you have from working together?  
  
c) What expectations do you have of me personally as a Nutritherapist / Naturopath?
  
- 3) What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, with 10 being 100% committed)  
0%    0    1    2    3    4    5    6    7    8    9    10    100%
  
- 4) a) What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health? (please list)  
  
b) What behaviors or lifestyle habits do you currently engage in regularly that you believe are self destructive lifestyle habits: (please list)
  
- 5) What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?
  
- 6) Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Are you currently receiving healthcare?      Yes       No

If yes, where and from whom: \_\_\_\_\_  
\_\_\_\_\_

If no, when and where did you last receive medical or health care? \_\_\_\_\_  
\_\_\_\_\_

What was the reason? \_\_\_\_\_  
\_\_\_\_\_

What are your most important health problems? List as many as you can in order of importance:

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_
- 4) \_\_\_\_\_
- 5) \_\_\_\_\_
- 6) \_\_\_\_\_
- 7) \_\_\_\_\_

**SUBMIT**