HEALTHY FOUNDATIONS
NATUROPATHIC CLINIC

Adult Intake Form

Dear New Patient;

Thank you for taking the time to fill out the following form. The information you are providing is extremely valuable, as it allows us to offer the best treatment options possible. We ask that you kindly return this form prior to your initial appointment, either via fax (705-243-5166), mail, or dropping it off at the clinic. If this is not possible, please bring the form to your appointment. Please know that the information gathered on this form will be treated in a strictly confidential manner.

What to expect at your first visit:

- Your first visit will be approximately 1 hour and 15 minutes long. During the first visit, your Naturopathic Doctor will review and discuss your patient intake form in more detail, answer any questions you may have, possibly perform a partial physical exam and then discuss treatment options.
- Some additional testing may be suggested during this visit (these tests are not included in the cost of the initial visit).

What to bring to your first visit:

- All the medications and supplements you are currently taking
- Any recent blood work or test results

Please feel free to call us at 705-243-5163 if you have any questions or concerns.
We look forward to meeting you!

Yours truly,

Dana Marshall, ND and Susan Joyce, ND
Healthy Foundations Naturopathic Clinic

"Providing our patients with the foundations for good health"

HEALTHY FOUNDATIONS - NATUROPATHIC CLINIC
291 Charlotte Street • Unit A • Peterborough, Ontario • K9J 2V6
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E • info@healthyfoundations.ca

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CONTACT INFORMATION

Today's Date: _____

Name: _____

Date of Birth: _____ Gender: ☐ Male ☐ Female

Age: _____

Phone:

Home _____ ☐ Preferred Contact Number

Cell _____ ☐ Preferred Contact Number

Work _____ ☐ Preferred Contact Number

Email Address: _____

I would like to receive communication from Healthy Foundations Naturopathic Clinic (i.e. E-newsletters, etc.) ☐ Yes ☐ No

Mailing Address: _____

_____

_____

Occupation: _____

Emergency Contact:

Name _____

Relation _____

Phone Number _____

How did you hear about our clinic ?

☐ Website ☐ Yellow Pages ☐ Referral (please see below)

☐ Radio ☐ Newspaper ☐ Other: _____

If referred, can you please provide by whom: _____

Do you have health insurance coverage for Naturopathic Medicine ? ☐ Yes ☐ No

CLINIC PARKING

Please note that there is first come, first serve parking available on the lot facing Stewart Street. There is metered parking on Charlotte Street (with 15 mins. free parking), one hour free parking on Stewart, south of Charlotte, and all day free parking on Stewart, north of Charlotte.

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HEALTH CONCERNS

What are your main health concerns (please list in order of importance):

1. _____
2. _____
3. _____
4. _____

Please check any Health Services you have tried in the **PAST (P)** or are using **CURRENTLY (C)**

Previous Naturopathic Doctor	☐ P ☐ C		Massage	☐ P ☐ C	
Chiropractor	☐ P ☐ C		Acupuncture	☐ P ☐ C	
Craniosacral Therapy	☐ P ☐ C		Physiotherapy	☐ P ☐ C	
Other: _____	☐ P ☐ C				

Please provide comments (where applicable) on the results of the above therapies:

_____
_____
_____
_____

Please fill out the following in regards to **CURRENT MEDICATIONS**:

MEDICATION	DAILY DOSE	FOR HOW LONG	REASON
1.			
2.			
3.			
4.			
5.			

Please fill out the following in regards to **CURRENT SUPPLEMENTS**:

SUPPLEMENT	DAILY DOSE	FOR HOW LONG	REASON
1.			
2.			
3.			
4.			
5.			

Do you take any 'over-the-counter' medications (i.e. Aspirin, Tums, etc.) ? Please list:

_____
_____

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PERSONAL MEDICAL HISTORY

Please list any allergies or sensitivities (i.e. food, medication, environmental) that you currently experience or or have previously experienced:

_____

_____

_____

Please indicate which of the following diagnostic tests you have had in the recent past and the results:

Colonoscopy	☐ Y ☐ N	RESULTS:	_____
Endoscopy	☐ Y ☐ N	RESULTS:	_____
Bone Mineral Density	☐ Y ☐ N	RESULTS:	_____
Mammogram	☐ Y ☐ N	RESULTS:	_____
Pap Test	☐ Y ☐ N	RESULTS:	_____
Prostate Exam	☐ Y ☐ N	RESULTS:	_____
Thyroid Function	☐ Y ☐ N	RESULTS:	_____
Liver Function	☐ Y ☐ N	RESULTS:	_____
Hormone Level	☐ Y ☐ N	RESULTS:	_____
Cholesterol	☐ Y ☐ N	RESULTS:	_____
Blood Sugar	☐ Y ☐ N	RESULTS:	_____

Please list any past injuries / hospitalizations (i.e. Car accidents, surgeries, etc.)

TYPE OF INJURY / SURGERY	HOSPITALIZATION	HOW DID IT HAPPEN ?	YEAR
	☐ Y ☐ N		
	☐ Y ☐ N		
	☐ Y ☐ N		
	☐ Y ☐ N		
	☐ Y ☐ N		

FAMILY MEDICAL HISTORY

Please indicate whether any of your family members have, or have had, the following:

TYPE OF INJURY	Mother	Father	Gr. Parent	Sibling	Child	Spouse
Cancer	☐	☐	☐	☐	☐	☐
Diabetes	☐	☐	☐	☐	☐	☐
Autoimmune Conditions (i.e. Lupus)	☐	☐	☐	☐	☐	☐
Arthritis	☐	☐	☐	☐	☐	☐
Substance Abuse	☐	☐	☐	☐	☐	☐
Depression	☐	☐	☐	☐	☐	☐
Inflammatory Bowel Disease	☐	☐	☐	☐	☐	☐
Osteoporosis	☐	☐	☐	☐	☐	☐
Lung Disease	☐	☐	☐	☐	☐	☐
Kidney Disease	☐	☐	☐	☐	☐	☐
Heart Disease	☐	☐	☐	☐	☐	☐
Fertility Concerns	☐	☐	☐	☐	☐	☐
Thyroid Concerns	☐	☐	☐	☐	☐	☐
Allergies	☐	☐	☐	☐	☐	☐
Other:	☐	☐	☐	☐	☐	☐

LIFESTYLE

Do you exercise ? ☐ Y ☐ N

If yes: (a) How often do you exercise ? _____ times per _____ (i.e. week, month, year)

(b) What type of exercise ?

_____

_____

Do you smoke ? ☐ Y ☐ N

If yes: (a) How many cigarettes ? _____ per day

Do you drink alcohol ? ☐ Y ☐ N

If yes: (a) How many drinks ? _____ per week

Do you drink coffee ? ☐ Y ☐ N

If yes: (a) How many cups ? _____ per day

Do you drink tea ? ☐ Y ☐ N

If yes: (a) How many cups ? _____ per day

Do you drink water ? ☐ Y ☐ N

If yes: (a) How many cups ? _____ per day

(b) What type ? ☐ Tap ☐ Spring ☐ Reverse Osmosis ☐ Distilled

Please rate your level of stress:

Low ☐ Medium ☐ High ☐

What are the main stressors in your life ?

_____

_____

Are you aware of any past or present toxin exposure ? ☐ Y ☐ N

Has there been an illness or event in your life from which you have never fully recovered ? ☐ Y ☐ N

Occupation: _____

Number of hours per week: _____

Shift work: ☐ Y ☐ N

How many hours per night do you sleep ? _____

Do you have any sleep concerns ? ☐ Y ☐ N

If yes, please explain:

_____

_____

_____

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MEN'S HEALTH ☐ *Not Applicable*

How often do you see a health care practitioner ? _____ times per _____ (i.e. month, year)

Do you have regular prostate exams ? ☐ Y ☐ N

When was your last prostate exam ? _____

Most recent PSA Reading: _____

How many times do you get up from your sleep to go to the washroom ? _____ per night

WOMEN'S HEALTH ☐ *Not Applicable*

Age of the onset of menses : _____

Are you menopausal ? ☐ Y ☐ N Date of your last menstrual period _____

My average period lasts (i.e. 5 days) _____ days

My entire menstrual cycle lasts (i.e. 28 days) _____ days

Do you experience:

(a) Bleeding between periods ? ☐ Y ☐ N
(b) An irregular cycle ? ☐ Y ☐ N

How heavy is your period ? ☐ Light ☐ Medium ☐ Heavy

What colour is the blood ? ☐ Light Red ☐ Bright Red ☐ Dark Red ☐ Brown ☐ Black

Do you :

(a) Experience clotting ? ☐ Y ☐ N
(b) Experience pain during your menstrual cycle ? ☐ Y ☐ N
(c) Ovulate on your own ? ☐ Y ☐ N

On what day of your cycle do you ovulate ? **DAY:** _____

Are you currently taking birth control ? ☐ Y ☐ N If yes, what type ? _____

Do you have premenstrual symptoms ? ☐ Y ☐ N

Have you ever had any of the following:

(a) Endometriosis ? ☐ Y ☐ N
(b) Ovarian Cysts ? ☐ Y ☐ N
(c) Fibroids ? ☐ Y ☐ N

Have you ever had any of the following in regards to your breasts (please circle) ?

Cysts ***Lumps*** ***Nipple Discharge*** ***Implants*** ***Surgery***

Date of your last:

(a) Breast Exam _____ (b) Mammogram _____ (c) PAP test _____

Have you ever had an abnormal PAP test ? ☐ Y ☐ N

Is there a family history of breast cancer ? ☐ Y ☐ N

Do you have any vaginal concerns (please circle) ? ***Discharge*** ***Itching*** ***Infection***

Do you experience mood swings ? ☐ Y ☐ N

How many pregnancies have you had ? _____ Number of children: _____

Did you have any difficulty conceiving ? ☐ Y ☐ N

Have you had any miscarriages ? ☐ Y ☐ N

If yes: When was your last miscarriage ? _____

How far along were you ? _____

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MEDICAL DETAILS

Please note any conditions you have had in the **PAST (P)** or are **CURRENTLY (C)** experiencing:

ENDOCRINE

- ☐ P ☐ C LOW BLOOD SUGAR
- ☐ P ☐ C THYROID CONCERNS
- ☐ P ☐ C SUDDEN WEIGHT CHANGE
- ☐ P ☐ C POOR CONCENTRATION
- ☐ P ☐ C EXCESSIVE THIRST
- ☐ P ☐ C EXCESSIVE HUNGER

HEAD, EARS, EYES, NOSE, MOUTH

- ☐ P ☐ C HEADACHES
- ☐ P ☐ C MIGRAINES
- ☐ P ☐ C DIZZINESS
- ☐ P ☐ C RINGING IN EARS
- ☐ P ☐ C IMPAIRED HEARING
- ☐ P ☐ C EAR INFECTIONS
- ☐ P ☐ C GLASSES / CONTACT LENSES
- ☐ P ☐ C BLURRED VISION
- ☐ P ☐ C FLOATERS
- ☐ P ☐ C DRY EYES
- ☐ P ☐ C EYE REDNESS
- ☐ P ☐ C LIGHT SENSITIVITY
- ☐ P ☐ C GLAUCOMA
- ☐ P ☐ C CATARACTS
- ☐ P ☐ C NOSEBLEEDS
- ☐ P ☐ C LOSS OF SMELL
- ☐ P ☐ C POST NASAL DRIP
- ☐ P ☐ C SINUS PROBLEMS
- ☐ P ☐ C HAYFEVER
- ☐ P ☐ C GUM PROBLEMS
- ☐ P ☐ C FREQUENT SORE THROAT
- ☐ P ☐ C MOUTH SORES
- ☐ P ☐ C LOSS OF TASTE
- ☐ P ☐ C JAW PAIN OR CLICKING
- ☐ P ☐ C SWOLLEN NECK GLANDS
- ☐ P ☐ C DRY TONGUE / MOUTH

SKIN

- ☐ P ☐ C ECZEMA
- ☐ P ☐ C PSORIASIS
- ☐ P ☐ C HIVES / RASHES
- ☐ P ☐ C ITCHING
- ☐ P ☐ C DRYNESS
- ☐ P ☐ C ACNE
- ☐ P ☐ C SKIN CANCER
- ☐ P ☐ C BOILS

CARDIOVASCULAR

- ☐ P ☐ C HIGH CHOLESTEROL
- ☐ P ☐ C PALPITATIONS
- ☐ P ☐ C CHEST PAIN
- ☐ P ☐ C HEART DISEASE
- ☐ P ☐ C HIGH BLOOD PRESSURE
- ☐ P ☐ C LOW BLOOD PRESSURE
- ☐ P ☐ C IRREGULAR HEART BEAT

VASCULAR / LYMPHATIC

- ☐ P ☐ C EASY BRUISING / BLEEDING
- ☐ P ☐ C DEEP LEG PAIN / CRAMPS
- ☐ P ☐ C COLD HANDS / FEET
- ☐ P ☐ C NUMBNESS IN EXTREMITIES
- ☐ P ☐ C SWELLING IN EXTREMITIES
- ☐ P ☐ C VARICOSE VEINS
- ☐ P ☐ C LYMPH NODE SWELLING

RESPIRATORY

- ☐ P ☐ C COUGH
- ☐ P ☐ C SHORTNESS OF BREATH
- ☐ P ☐ C ASTHMA
- ☐ P ☐ C BRONCHITIS
- ☐ P ☐ C PNEUMONIA
- ☐ P ☐ C EMPHYSEMA
- ☐ P ☐ C DIFFICULTY BREATHING
- ☐ P ☐ C PHLEGM

MEDICAL DETAILS (continued…)

Please note any conditions you have had in the **PAST (P)** or are **CURRENLTY (C)**:

MUSCLE AND JOINT

- ☐ P ☐ C MUSCLE CRAMPS / SPASMS
- ☐ P ☐ C MUSCLE TENSION
- ☐ P ☐ C MUSCLE WEAKNESS
- ☐ P ☐ C JOINT SWELLING
- ☐ P ☐ C BACKACHE
- ☐ P ☐ C ARTHRITIS
- ☐ P ☐ C SCIATICA
- ☐ P ☐ C OSTEOPOROSIS
- ☐ P ☐ C BONE PAIN
- ☐ P ☐ C FIBROMYALGIA

GASTROINTESTINAL

- ☐ P ☐ C CONSTIPATION
- ☐ P ☐ C DIARRHEA
- ☐ P ☐ C HEMORRHOIDS
- ☐ P ☐ C NAUSEA / VOMITING
- ☐ P ☐ C HEARTBURN / INDIGESTION
- ☐ P ☐ C EXCESSIVE GAS / BLOATING
- ☐ P ☐ C BLOOD IN STOOL
- ☐ P ☐ C GALLBLADDER PROBLEMS
- ☐ P ☐ C COLITIS OR CROHN'S
- ☐ P ☐ C DIVERTICULITIS
- ☐ P ☐ C ULCERS

URINARY

- ☐ P ☐ C FREQUENT URINARY TRACT INFECT.
- ☐ P ☐ C FREQUENCY AT NIGHT
- ☐ P ☐ C INCREASED FREQUENCY
- ☐ P ☐ C REDUCED URINE FLOW
- ☐ P ☐ C BLOOD IN URINE
- ☐ P ☐ C INABILITY TO HOLD URINE
- ☐ P ☐ C PAIN ON URINATION
- ☐ P ☐ C STRONG SMELLING URINE
- ☐ P ☐ C KIDNEY STONES

NEUROLOGICAL

- ☐ P ☐ C DIZZINESS / VERTIGO
- ☐ P ☐ C LOSS OF BALANCE
- ☐ P ☐ C MUSCLE WEAKNESS
- ☐ P ☐ C INCOORDINATION
- ☐ P ☐ C FAINTING
- ☐ P ☐ C LOSS OF MEMORY
- ☐ P ☐ C INVOLUNTARY MOVEMENTS
- ☐ P ☐ C SPEECH PROBLEMS
- ☐ P ☐ C NUMBNESS AND TINGLING