NORTH SAUGEEN NATUROPATHIC CLINIC
21, 1st Avenue South
Chesley, ON, N0G1L0

Phone: (905) 237-8521
Fax: (905) 237-8531
www.northsaugeenclinic.com

Adult Intake Form

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

Name_____ Date _____

Date of birth: Date _____ Month _____ Year_____ Sex / Gender _____

Address_____

_____

_____

_____ Postal code _____

E-mail Address _____

Home Telephone Number _____ Work _____

May we leave messages relating to your visits? ☐Y / ☐N Which Phone Number? _____

Emergency contact: Name_____ Phone number _____ Relation _____

How did you hear about our Clinic? Please check one of the following:

☐NSNC Website	☐Medical Doctor
☐NSNC Open House	☐Media/TV Article
☐NSNC Staff	☐Corporate Health/Wellness Event
☐NSNC Patient	☐Newsletter Delivery to Residence
☐Friend	☐NSNC Information Session
☐Family	☐Other _____

Referred by _____

Referred to _____

(Naturopathic Doctor at NSNC)

Other health care providers you are seeing:

1. Name _____	2. Name _____	3. Name _____
Address _____	Address _____	Address _____
_____	_____	_____
Phone (_____)_____	Phone (_____)_____	Phone (_____)_____
Fax (_____)_____	Fax (_____)_____	Fax (_____)_____

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Last physician or health practitioner seen _____ When _____

When was your last physical exam? _____ Were blood tests done? ☐Y / ☐N

Blood type _____

If you are female are you currently pregnant? ☐Yes / ☐No

What is your main reason of coming today? _____

_____

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

1. _____How long? _____
2. _____How long? _____
3. _____How long? _____
4. _____How long? _____
5. _____How long? _____

What kind of conventional treatment have you received?

_____

_____

_____

Please mark all of the following complimentary health care practitioners you have seen:

☐Naturopathic Doctor ☐Chiropractor ☐Acupuncturist ☐Massage Therapist ☐Osteopath ☐Other: _____

What was the therapy and what were the results?

_____

_____

MEDICAL HISTORY

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

How often do you get colds, flus, sore throats in a year? _____

What is your current level of energy from 1 to 10 (10 = the best you have ever felt): _____

What is your current approximate weight _____One year ago _____ Ideal weight? _____ Height _____

Please list 5 most significant stressful events in your life:

1) _____ Date: _____
2) _____ Date: _____
3) _____ Date: _____
4) _____ Date: _____
5) _____ Date: _____

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Are any of these situations continuing to impact your life? ☐Y / ☐N (*If yes please circle the number.*)

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist?

_____

Have you in the past / when? _____

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

_____

_____

_____

_____

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

_____

_____

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

_____

_____

_____

_____

Please list <u>past</u> prescription medications.

_____

_____

_____

_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following?

☐Aspirin ☐Laxatives ☐Antacids ☐Diet pills ☐Birth control: pills / implants / injections (circle)

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day_____

Recreational drugs—what and how often _____

Have you been treated for alcoholism? ☐Y / ☐N How often? _____

Have you been treated for drug dependence? ☐Y / ☐N How often? _____

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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 caused adverse reactions: _____

_____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? ☐Y / ☐N

DIET

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

_____

_____

_____

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

_____

_____

_____

Do you eat 3 meals daily? ☐Y / ☐N

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Have you ever fasted? ☐Y / ☐N What type of fast did you do (i.e. juice or water)? _____

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FAMILY HISTORY

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

Condition	Please indicate which family member
Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other Mental Illness	
Drug Abuse/Alcoholism	
Kidney Disease	
Stroke	
Tuberculosis	
Other _____	

☐ I don't know my family medical history

HOME/WORK ENVIRONMENT

Marital status _____ Number of children _____

Occupation _____

Do you enjoy your work? ☐Y / ☐N Do you take vacations? ☐Y / ☐N

Have you travelled outside of Canada in the last 5 years? ☐Y / ☐N

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

_____

_____

Hobbies _____

Who do you currently live with? ☐Spouse ☐Partner ☐Parents ☐Friends ☐Children ☐Alone

Are you currently in a happy and supportive relationship? ☐Very ☐Mostly ☐Somewhat ☐No

How would you describe the emotional climate of your home? _____

_____

What do you enjoy most in your life? _____

_____

What do you worry about most in your life? _____

_____

What nurtures you? _____

Do you have a religious or spiritual practice? _____

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PERSONAL HABITS

Do you exercise regularly? ☐Y / ☐N What do you do for exercise, how much, how often (times x week)?

_____

_____

How is your body temperature, compared to others? ☐Warmer ☐Cooler ☐Average

Do you have any difficulty perspiring? ☐Y / ☐N Does your sweat have a strong odour? _____

Do you perspire when exercising? ☐Lightly ☐Moderately ☐Heavily

Do you perspire at times other than when you exercise? When? _____

Do you experience night sweats? ☐Y / ☐N How frequently? _____

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) _____

Do you have problem falling asleep? ☐Y / ☐N Staying asleep? ☐Y / ☐N How much do you sleep? _____ hours

How many hours do you think you need _____ Do you wake up refreshed? _____

Do you nap or rest horizontally throughout the day? ☐Y / ☐N For how long? _____

Do you watch television? ☐Y / ☐N How many hours / day? _____

How do you learn? ☐I read ☐I listen (lectures) ☐Television ☐Through stories ☐Very visual

OCCUPATIONAL / HOUSEHOLD

Are you exposed to significant tobacco smoke (work, home, etc.)? ☐Y / ☐N

Are you frequently exposed to animals (work, pets, etc.)? ☐Y / ☐N

How is your home heated? _____

Is your home damp or moldy at all? ☐Y / ☐N

Do you have any specialized air filtration system at home? ☐Y / ☐N

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

_____

_____

What do you use for drinking water? ☐Tap water ☐Bottled Water ☐Filtered Water ☐Reverse Osmosis

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

_____

_____

_____

Thank you for taking time to fill in this questionnaire. It will be a valuable resource to evaluate your current health.

For file use only