Contact Information

Full Name: _____ Age:_____

Date of Birth:____/____/_____ (dd/mm/yyyy) Gender:_____

Telephone- Home: _____ Cell: _____ Work: _____

Preferred form of contact for reminder/follow-up calls:

□ Home □ Cell □ Work □ email May we leave a message: □ Yes □ No

Full Address: _____

Email address:_____ (Used only for office purposes and for clinic newsletters. Please check this box if you don't want to receive them □)

Emergency Contact

Name:_____ Relation to contact:_____

Emergency Contact phone number:_____

Other Health Care Providers (Eg. Family Doctor)

Name	Title	Location

How Did You Hear About Me?

□ Search engine (ie. Google)

□ Yellow Pages □ Relative

□ Co-worker □ Friend

□ Medical Doctor □ Health Food Store

□ Other (please specify):_____

Erin Balodis MSc, ND **www.erinbalodis.com**

Naturopathic Intake Form

Date:_____

***PLEASE READ*:** This confidential record of your medical history will be kept by the Naturopathic Doctor and will not be released to any individual except when you have authorized this release in writing or when required by law.

*Naturopathic Doctors look at the entire picture of a person's health; physically, mentally and emotionally. Please complete this form as thoroughly as possible to optimize your health care outcomes. Completing all of the questions in this form are for your benefit, however if you are unsure how to answer any of the following questions, they can reviewed with the Naturopathic Doctor at your first visit. Parents/guardians may complete this form for children under 16yrs of age.

General Intake

What is your main reason for seeking Naturopathic care?_____

How long have you had this concern?_____

Previous practitioners consulted for this condition: _____

What types of therapy have you tried for this problem(s)? ☐ pharmaceutical drugs ☐ diet modification ☐ vitamin/mineral supplementation ☐ herbs ☐ homeopathy ☐ chiropractor ☐ acupuncture ☐ other

Please list any other health concerns or goals you wish to address, in order of importance:

_____

_____

_____

Sexual Orientation: _____ Marital status: _____

Number of dependents (if applicable)? _____

Occupation: _____ Shift work? ☐ Y ☐ N Do you enjoy your work? ☐ Y ☐ N ☐ Sometimes

Is your job associated with potentially harmful chemicals (eg pesticides, solvents, radioactivity) Please specify:

_____

How is your home heated? _____

Hours per day you spend: Driving: _____ Watching TV: _____ In front of a computer/screen_____

Circle the level of stress you are presently experiencing in your life (10= highest possible): 1 2 3 4 5 6 7 8 9 10

Please list the major causes of stress for you (work, finances, relationship, health, etc.) _____

_____

How do you cope with stress? _____

Have you experienced any major trauma, loss or life changing significant events?_____

_____

_____

Do you have a strong emotional support network? □ Y □ N Who (family members, friends, church groups, etc)?

_____

Have you worked with a counselor, psychologist, or psychiatrist, etc? □ Never □ Currently □ In the past

If so, for how long? _____

When was your last vacation? _____

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

How would you describe your general state of health: □ excellent □ good □ fair □ poor

Do you wear a medical alert bracelet/tag? □ Y □ N For what condition? _____ What is your blood type? ___

Do you wear: □ corrective lenses □ dentures □ hearing aid □ medical devices/prosthetics/implants

For the following tables, please use the back of this page if more room is required

Medical Conditions: Please indicate any conditions, serious illnesses, major injuries, surgeries or hospitalizations

Description	Year	Outcome

Please list any allergies or sensitivities (food, medications, environmental, insects) you currently have or have had previously:

Allergy	Reaction

Current Medications/Supplements: Please list ALL medications or supplements you currently take on a regular basis OR Bring all Medications/Supplements to initial appointment

Medication/Natural Product (including brand, if known)	Dose/Quantity per day (if known)	Length of Use	Condition it is Treating

List any abnormal test results you have had in the past, that you are aware of (eg. high cholesterol, low iron, etc.):

_____

_____

Screening tests: Please indicate when you last had the following screening tests (if known)

Screen/Test	Year	Screen/Test	Year
PAP (females)		DEXA scan	
Digital Rectal Exam (males)		Complete Blood Count (CBC)	
PSA test (males)		Cholesterol	
Breast exam (both)		Blood glucose	
Mammogram		Other: _____	

Which conditions do you have now (N) or have you had in the past (P)?

	N	P		N	P		N	P		N	P
Alcoholism			Eye Infections			Malaria			Scarlet Fever		
Allergies			Fainting			Migraine			Seizures		
Asthma			Fatigue			Miscarriage			Sexual Abuse		
Arthritis			Gallstones			Mono			Sinusitis		
Acne			Gout			Mumps			Small Pox		
Anemia			Gas/Bloating			Numbness/Tingling			Speech Problems		
Anxiety			Hay Fever			Parasites			Strep Throat		
Balance Problems			Headache			Physical Abuse			Stroke		
Cancer			Heartburn			Polio			STD/STI		
Canker sores			Heart Disease			Poor Memory			Thyroid problems		
Child Abuse			Hepatitis			Pneumonia			Tonsillitis		
Cold hands/feet			Herpes			Psoriasis			Tuberculosis		
Diabetes			Hemorrhoids			Rape			Varicose Veins		
Depression			High Cholesterol			Rectal Bleeding			Visual problems		
Ear Infections			High Blood Pressure			Reflux			Warts		
Eczema			HIV/AIDS			Rheumatic Fever			Weight Problems		
Emotional Abuse			HPV			Ringing in the ears			Yeast Infections		
Epilepsy			Jaundice								

Date of last complete physical exam: _____ Current Weight:_____ Height:_____

Weight one year ago:_____ Are you satisfied with your current weight? ☐ Y ☐ N (If no, Ideal Weight:_____)

Have you taken antibiotics within the last 5 years? ☐ Y ☐ N If yes, approximately how many times? _____

Females: Are you currently: ☐ Having periods ☐ menopausal ☐ post- menopausal
Could you be pregnant? ☐ Y ☐ N Date of your last period: _____
Age at first period? _____ Have your periods been regular? _____ How long is your cycle:_____

PMS symptoms? _____ Symptoms during your period? _____

Diet and Health Habits

General energy level out of 10 (1= lowest, 10= highest): ____What time of day is it highest? _____lowest? _____

What time of day do you eat the following: Breakfast: _____ Lunch: _____ Dinner: _____

Are you on a special diet? ☐ Y ☐ N Explain: _____

Are there any foods that you crave: _____

How many glasses of water do you drink throughout an average day? ____

What do you use as drinking water? ☐ Tap ☐ Bottled ☐ Filtered ☐ Reverse osmosis Other:_____

Do you drink: ☐ coffee ☐ tea ☐ pop How many per day?_____

Please provide examples of things you typically consume for:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Do you have digestive difficulty with any specific foods? Which? _____

How many bowel movements do you have/day? _____ Do you frequently have loose stools? □ Y □ N

Do you frequently have to strain to have a bowel movement? □ Y □ N Have you had blood in your stool? □ Y □ N

Do you use tobacco products? □ Yes □ No How often?_____

Are you exposed to tobacco products in your home or workplace? □ Yes □ No

Do you consume alcohol? □ Yes □ No How many drinks per day or week?_____

Do you use recreational drugs? □ Yes □ No How often?_____

Which of the following do you currently use?

	How Often/How much?		How Often/How much?
Laxatives		Sedatives/Sleeping Pills	
Aspirin		Diet Pills	
Antacids		Hormones (incl fertility tx)	

Do you exercise? If yes, what do you do and how often? _____
_____

How many hours of sleep do you get each night? _____Do you wake feeling rested? □ Y □ N Do you nap? □ Y □ N

Do you wake in the night? □ Y □ N For any particular reason?_____ At any particular time? _____

Have any of your family members had any of the following? (Parents, Grandparents, Siblings, Aunts, Uncles)

Condition	Who	Condition	Who	Condition	Who
Alcoholism		Celiac Disease		Lupus	
Allergies		Depression		Mental Illness	
Alzheimer's		Diabetes		Multiple Sclerosis	
Anemia		Drug Addiction		Parkinson's	
Arthritis		Heart Disease		Stroke	
Asthma		High Blood Pressure		Tuberculosis	
Cancer		Kidney Disease		Other	

<u>Childhood History</u>

What was your mother's state of health during her pregnancy (if known) _____

How was your birth? Any complications?_____

Were you breastfed? □ Y □ N If yes, for how long? ____

Were you vaccinated/immunized? □ Y □ N If yes, any reactions?_____

Which 'childhood' illnesses did/do you have?

□ attention deficit disorder □ eczema □ german measles □ mumps □ rheumatic fever □ chicken pox
□ frequent ear infections □ meningitis □ red measles □ whooping cough □ thrush/candida

Please use the space below to add any additional information that has not been covered in this questionnaire.

_____

_____

Thank-you for filling out this lengthy form to the best of your ability!