360° Health Care

Confidential Adult Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

Personal Information

Name _____ Date _____

Date of birth _____ Age _____ Gender: ❍ Male ❍ Female

Address _____ City _____

Province _____ Postal code _____

Phone: Home _____ Work _____ Other _____

Email _____ May we leave messages relating to your visit? ❍ Yes ❍ No

Other health care providers (Medical Doctor, specialists, chiropractors, etc.)

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Name: _____ Phone number: _____

Emergency contact person

Name: _____ Relationship: _____

Phone: _____ Alternate number: _____

How did you find out about 360 Health Care?

❍ Referral from _____ ❍ Chatelaine ❍ Today's Parent

❍ Internet search ❍ Yellow Pages ❍ Other _____

Would you like to receive our seasonal newsletter with information on health and upcoming events? Your email address will not be shared. ❍ Yes ❍ No

What are the main health concerns you would like addressed?

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

Medical History

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

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

_____

_____

_____

Do you have any allergies or sensitivities (food, medicine, environmental, other)?

_____

_____

_____

Please list all current medications, including dosage, duration of use and reason for use.

Medication	Dose	Duration	Reason/ condition treating

Please list all past prescription medications

_____

_____

_____

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Please list all natural health products (supplements, vitamins, herbs, homeopathics).

Natural Health Product	Dose	Duration	Reason/ condition treating

Approximately how many times have you been treated with antibiotics? _____

Please indicate which vaccinations you have received

❍ DPT (diphtheria, pertussis, tetanus) ❍ MMR (measles, mumps, rubella) ❍ Influenza

❍ Haemophilus influenza B ❍ Hepatitis A ❍ Hepatitis B

❍ Tetanus booster; when? _____ ❍ Smallpox ❍ Polio

❍ Other _____

Please indicate any adverse reactions you may have had to a past immunization

_____

_____

Do you regularly use any of the following?

❍ Antacids ❍ Aspirin/ Tylenol/ Advil ❍ Birth control pills ❍ Diet pills ❍ Laxatives

❍ Alcohol – form and amount/ day _____

❍ Caffeine – form and amount/ day _____

❍ Tobacco – form and amount/ day _____

❍ Recreational drugs – what and how often? _____

Do you get regular screening exams done by another doctor (PAP, blood tests, etc.)?
❍ Yes ❍ No

If female, are you currently pregnant? ❍ Yes ❍ No

Are you planning on becoming pregnant while under Naturopathic care? ❍ Yes ❍ No

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Diet

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

_____

_____

_____

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

_____

_____

_____

Describe a typical day's diet.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

List any food cravings regardless of their nutritional value (sweets, salty, water, etc.)

_____

_____

Family History

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

❍ Alcoholism	❍ Depression	❍ Gallstones	❍ Osteoporosis
❍ Allergies	❍ Other mental illness	❍ Heart disease	❍ PMS
❍ Arthritis	❍ Diabetes	❍ High blood pressure	❍ Skin disease
❍ Asthma	❍ Drug abuse	❍ Kidney disease	❍ Stroke
❍ Cancer	❍ Endometriosis	❍ Multiple sclerosis	❍ Thyroid disease
(type _____)	❍ Epilepsy	❍ Obesity	❍ Tuberculosis

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Lifestyle and Environment

Hobbies _____

Do you exercise regularly? ❍ Yes ❍ No

What do you do for exercise, how often and for how long? _____

_____

_____

Are you exposed to significant tobacco smoke at work or home? ❍ Yes ❍ No

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

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

_____

How would you describe the emotional climate of your home?

_____

_____

How would you rate your stress levels?

❍ Overwhelming ❍ High ❍ Moderate ❍ Low ❍ Minimal

How many hours of sleep do you average per night? _____

Do you have difficulty falling asleep? ❍ Yes ❍ No

Do you have trouble staying asleep? ❍ Yes ❍ No

Do you wake feeling rested? ❍ Yes ❍ No

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

_____

_____

_____

_____

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Review of Systems

For the following list of symptoms, indicate with a "✔" for those that you currently experience, or "**p**" for those that you've had in the past:

SKIN:
- ❑ rashes
- ❑ eczema
- ❑ psoriasis
- ❑ vitiligo
- ❑ dryness
- ❑ hives
- ❑ acne
- ❑ warts

HEAD:
- ❑ head injury
- ❑ headaches/migraines
- ❑ vertigo/dizziness
- ❑ hair loss
- ❑ dandruff

EYES:
- ❑ redness
- ❑ excessive tearing
- ❑ double/blurred vision
- ❑ spots/floaters
- ❑ flashing lights
- ❑ glaucoma
- ❑ cataracts
- ❑ discharge/infection

EARS:
- ❑ infection
- ❑ ringing in ears (tinnitus)
- ❑ hearing loss

NOSE & SINUSES:
- ❑ frequent colds
- ❑ nasal stuffiness
- ❑ loss of smell
- ❑ nose bleeds
- ❑ chronic runny nose
- ❑ sinus infections
- ❑ nasal polyps

MOUTH & THROAT:
- ❑ bleeding gums/gingivitis
- ❑ sores in mouth
- ❑ thrush
- ❑ enlarged lymph glands
- ❑ torticollis/stiff neck

RESPIRATORY:
- ❑ cough
- ❑ wheezing
- ❑ asthma
- ❑ bronchitis
- ❑ pneumonia
- ❑ emphysema
- ❑ coughing up blood
- ❑ tuberculosis

CARDIOVASCULAR:
- ❑ rapid heart beat
- ❑ high blood pressure
- ❑ chest pain
- ❑ palpitations
- ❑ heart murmurs
- ❑ rheumatic fever
- ❑ difficult breathing
- ❑ leg cramps
- ❑ deep leg pain/ thrombophlebitis
- ❑ edema/swollen ankles
- ❑ cold hands/feet
- ❑ hot flashes

GASTROINTESTINAL:
- ❑ trouble swallowing
- ❑ nausea or vomiting
- ❑ regurgitation/heartburn
- ❑ indigestion
- ❑ bloating
- ❑ abdominal pain
- ❑ excessive passing of gas
- ❑ ulcer
- ❑ hypoglycemia
- ❑ diabetes
- ❑ jaundice
- ❑ hepatitis
- ❑ colitis / Crohn's disease
- ❑ constipation
- ❑ blood in stool
- ❑ diarrhea
- ❑ hemorrhoids
- ❑ eating disorder

GENITO-URINARY:
- ❑ urgency
- ❑ dribbling / leaking
- ❑ frequency
- ❑ incontinence
- ❑ burning/pain on urination
- ❑ urinary tract infections
- ❑ kidney infection
- ❑ kidney stones
- ❑ sexually transmitted diseases (HPV, etc)

GENERALS:
- ❑ noticeable weight loss
- ❑ noticeable weight gain
- ❑ fatigue
- ❑ night sweats
- ❑ profuse perspiration
- ❑ weakness

FEMALE:
- ❑ PMS
- ❑ menopause
- ❑ low libido
- ❑ yeast infection/vaginitis
- ❑ vaginal dryness
- ❑ painful periods
- ❑ irregular periods
- ❑ excessive discharge
- ❑ miscarriage(s)
- ❑ pregnancy(s)
- ❑ abortion
- ❑ endometriosis
- ❑ uterine fibroids
- ❑ cervical dysplasia
- ❑ fibrocystic/breast problems

MALE:
- ❑ BPH/enlarged prostate
- ❑ prostatitis
- ❑ discharge
- ❑ low libido/erectile dysfunction

HAEMATOLOGICAL:
- ❑ anemia
- ❑ easy bleeding
- ❑ easy bruising
- ❑ varicose veins/spider veins
- ❑ any past blood transfusions
- ❑ hepatitis A, B or C
- ❑ HIV

MUSCULOSKELETAL:
- ❑ muscle pains
- ❑ joint pains
- ❑ osteoarthritis
- ❑ back pain
- ❑ muscle spasms/cramps
- ❑ joint swelling
- ❑ gout

NEUROLOGICAL:
- ❑ fainting/black outs
- ❑ numbness/loss of sensation
- ❑ tremors/involuntary movements
- ❑ tingling/ "pins & needles"
- ❑ loss of balance
- ❑ paralysis
- ❑ speech problems
- ❑ memory loss
- ❑ loss of sleep
- ❑ nervousness/tension
- ❑ irritability
- ❑ depression

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