



Confidential Adult Intake Form

Please complete the following form in order to provide your doctor with the background information she requires to ensure you receive comprehensive care. It should take 15-20 minutes.

Personal Information

Name _____	Date _____
Date of birth _____	Age _____
Gender: <input type="radio"/> Male	<input type="radio"/> Female
Address _____	City _____
Province _____	Postal code _____
Phone: Home _____	Work _____
Other _____	
Email _____	May we leave messages relating to your visit? <input type="radio"/> Yes <input type="radio"/> No
Marital Status: <input type="radio"/> Single <input type="radio"/> Married <input type="radio"/> Common law <input type="radio"/> Same sex <input type="radio"/> Widowed <input type="radio"/> Divorced <input type="radio"/> Separated	
Number of children: _____	
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 Dr. Lisa Watson?

- Referral from _____
- Today's parent/Chatelaine
- Global News
- Internet search
- Health Naturally on the iPad
- 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



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)
- Haemophilus influenza B
- Tetanus booster; when? _____
- Other _____
- MMR (measles, mumps, rubella)
- Hepatitis A
- Smallpox
- Influenza
- Hepatitis B
- Polio

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



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

- | | | | |
|----------------------------------|--|---|---------------------------------------|
| <input type="radio"/> Alcoholism | <input type="radio"/> Depression | <input type="radio"/> Gallstones | <input type="radio"/> Osteoporosis |
| <input type="radio"/> Allergies | <input type="radio"/> Other mental illness | <input type="radio"/> Heart disease | <input type="radio"/> PMS |
| <input type="radio"/> Arthritis | <input type="radio"/> Diabetes | <input type="radio"/> High blood pressure | <input type="radio"/> Skin disease |
| <input type="radio"/> Asthma | <input type="radio"/> Drug abuse | <input type="radio"/> Kidney disease | <input type="radio"/> Stroke |
| <input type="radio"/> Cancer | <input type="radio"/> Endometriosis | <input type="radio"/> Multiple sclerosis | <input type="radio"/> Thyroid disease |
| (type _____) | <input type="radio"/> Epilepsy | <input type="radio"/> Obesity | <input type="radio"/> Tuberculosis |



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?



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