Primary Care Naturopathic Clinic

Date:	

INTAKE FORM AND REVIEW OF SYSTEMS (PLEASE PRINT)

All questions contained in this questionnaire are strictly confidential
and will become part of your medical record.

Name *(First, Last name):*	
Gender	
Age:	
Date of Birth: *(day, month, year)*	
Height:	
Weight:	
Occupation:	

PERSONAL HEALTH CONCERNS

Health Concern #1	
What is your health concern?	
When did it start?	
How frequently do you experience it?	
If your health concern is pain, please describe its location and characteristics (for example: left shoulder – sharp)	
How intense is it? Please rate it from 1 to 10; 10 being extremely intense	
Does it improve with any condition or any particular time of day or night?	
How is it being treated?	
How was it treated in the past?	
How does it affect your daily activity?	
What conditions or situations make it worse?	

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Health Concern #2	
What is your health concern?	
When did it start?	
How frequently do you experience it?	
If your health concern is pain, please describe its location and characteristics (for example: left shoulder – sharp)	
How intense is it? Please rate it from 1 to 10; 10 being extremely intense	
Does it improve with any condition or any particular time of day or night?	
How is it being treated?	
How was it treated in the past?	
How does it affect your daily activity?	
What conditions or situations make it worse?	

Health Concern #3	
What is your health concern?	
When did it start?	
How frequently do you experience it?	
If your health concern is pain, please describe its location and characteristics (for example: left shoulder – sharp)	
How intense is it? Please rate it from 1 to 10; 10 being extremely intense	
Does it improve with any condition or any particular time of day or night?	
How is it being treated?	
How was it treated in the past?	
How does it affect your daily activity?	

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What conditions or situations make it worse?	

Other Concerns	
List any other health concerns you may have	
1.	
2.	
3.	
4.	
5.	

GENERAL			
	Do you have any disabilities?	☐ Yes	☐ No
	Any weight loss in the last month?	☐ Yes	☐ No
	Allergies (Food, supplements, drugs); If so, what are they?	☐ Yes	☐ No
	Environmental/seasonal allergies	☐ Yes	☐ No
	Are you pregnant? Trying to conceive? Breastfeeding?	☐ Yes	☐ No

List all natural supplements you are currently taking:		
Name	Dosage	Frequency Taken

List all medication including over-the-counter drugs (including BCP, Aspirin) you are currently taking:	

Do you eat at restaurants or do take-out? If so, how many times per week?			☐ Yes	☐ No
Do you drink?	☐ Coffee	☐ Tea	☐ Cola	☐ None
# of cups/cans per day?				
Do you drink alcohol? If yes, what kind?			☐ Yes	☐ No
How many drinks per week?				
Do you use tobacco?			☐ Yes	☐ No
Cigarettes – pks./day		Cigars - #/day		
Do you currently use recreational or street drugs?			☐ Yes	☐ No
Energy level – Please rate out of 10; 10 being the highest				
At waking				
Noon				
Mid-afternoon				
At 6:00 pm				
At 10:00 pm				
Exercise/Activity level (please indicate type if any and how many times per week)				
Do you have stress at home, at work, and/or in a relationship?			☐ Yes	☐ No
What are your coping skills/support/hobbies?				
How many children do you have?				

FAMILY MEDICAL HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Children		
Mother					
Siblings			**Grandmother** *Maternal*		
			Grandfather *Maternal*		
			Grandmother *Paternal*		

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			Grandfather *Paternal*		

Personal medical history (hospitalization, diagnoses), including list of sexually transmitted diseases

Date	Conditions	Date	Conditions

Immunizations and dates:	☐ Tetanus booster		☐ Flu	
	☐ Hepatitis A		☐ Shingles	
	☐ Hepatitis B		☐ HPV	
	Other, please list:			

ENVIRONMENTAL MEDICAL QUESTIONS

Do you have any pets? If so please list.	☒ Yes	☐ No
What is your job/occupation?		
Does your job, home or hobby expose you to chemicals?	☐ Yes	☐ No
Does the hobby of someone close to you potentially expose you to any chemicals or toxins?	☐ Yes	☐ No
Do you or your partner sleep on a memory foam mattress or pillow?	☐ Yes	☐ No
Have you had any water leakage at home, cottage, or workplace recently or in the past?	☐ Yes	☐ No
How often do you dry clean your clothes?		
Do you have amalgam fillings in your teeth?	☐ Yes	☐ No
Do you use bleach as part of your cleaning supply?	☐ Yes	☐ No
Please list the brand names of all of your cleaning supplies and laundry detergent?		
Have you been in contact with broken fluorescent light bulb?	☐ Yes	☐ No

How often do you eat dark chocolate?	

How many times a week do you eat fish? Please indicate the types of fish you eat.

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Review of Symptoms

GENERAL

☐ Fatigue	☐ Poor appetite	☐ Heavy appetite	☐ Cravings:	☐ Strong thirst for (cold or hot drinks)	☐ Sudden energy drop at ____ o'clock
☐ Peculiar taste or smells	☐ Cold hands	☐ Cold feet	☐ Cold back	☐ Cold abdomen	☐ Bleeding or bruising easily
☐ Lumps or masses	☐ Fever or chills	☐ Weight changes	☐ Stressful family life or job		

EYES

☐ Glasses or contacts	☐ Visual changes	☐ Itchy or watery eyes	☐ Eye pain, strain	☐ Cataracts	☐ Dizziness
☐ Seeing spots in the visual field	☐ Blurry vision	☐ Night blindness	☐ Sensitivity to light		

NOSE/THROAT/HEAD

☐ Nose bleeds	☐ Runny nose or congestion	☐ Hoarse voice	☐ Recurrent sore throats	☐ Regular clearing of throat	☐ Spitting up mucus
☐ Sensation of something in throat	☐ Dry throat	☐ Teeth problems	☐ Gum problems	☐ Jaw clicking	☐ Sore lips or tongue
☐ Hair loss	☐ Dandruff	☐ Facial pain or weakness	☐ Migraines	☐ Tension headaches	☐ Other head or neck problems
☐ Sinus pain/infection	☐ History of head injury				

EARS

☐ Difficulty hearing	☐ Hearing aid	☐ Ear pain	☐ Ear drainage	☐ Recurrent infection	☐ Ringing in the ear
☐ Difficulty with balance	☐ Dizziness	☐ Other			

CARDIOVASCULAR

☐ Chest pain/tightness	☐ History of heart attack	☐ Palpitation	☐ Fainting spells	☐ Fluid retention	☐ Swollen limbs

☐ Shortness of breath while lying down or walking	☐ High blood pressure	☐ Low blood pressure	☐ Fainting	☐ Cold hands and feet	☐ Dizziness
☐ Irregular heart beat/murmurs	☐ Fatigue	☐ Other heart problems	☐ Nose bleeds		

RESPIRATORY

☐ Hoarse voice	☐ Shortness of breath	☐ Cough or congestion	☐ Wheezing	☐ Coughing up phlegm	☐ Coughing up blood
☐ currently smoke cigarettes or history of smoking	☐ Exposure to second hand smoke	☐ Post nasal drip	☐ Recurrent pneumonia/bronchitis	☐ Sinus pain or infection	☐ Asthma
☐ Difficulty breathing when lying down	☐ Other lung issues				

GASTROINTESTINAL

☐ Bloating	☐ Excess gas	☐ Blood in stools	☐ Pain during or after bowel movement	☐ Diarrhea alternating with constipation	☐ Nausea or vomiting
☐ Pain/cramps in the abdomen	☐ Pain radiating to the back	☐ Heart burn	☐ Difficulty swallowing solids or liquids	☐ Aversion to cigarette smoke	☐ Itchy skin/rash
☐ Bad breath	☐ Belching	☐ Sensitive abdomen	☐ Rectal leakage or pain	☐ Hemorrhoids	
Colour of bowel movement:	☐ Pale coloured stool	☐ light brown/ yellowish	☐ Brown	☐ Black	☐ Greenish
Consistency of bowel movement:	☐ Soft	☐ Watery	☐ Hard	☐ Well formed	☐ Contains Undigested food/blood/mucous
Number of bowel movements per **week.**	☐ Laxative use	☐ Jaundice / yellowish tone to the skin or eyes	What was the date of your last colonoscopy?		

GENITOURINARY					
☐ Pain or stinging with urination	☐ Urinating at night –If yes, how many times?	☐ Blood in urine	☐ Leakage of urine/Urgency to urinate	☐ Change in force of stream	☐ Cloudy urine
☐ History of kidney stones	☐ Unable to hold in urine	☐ Sexually transmitted disease	☐ Pain during intercourse (female)	☐ Impotency (male)	
HEMATOLOGY					
☐ Easy bruising	☐ Enlarged lymph nodes	☐ Anemia	☐ Past blood transfusion	☐ Bleeding gums (while brushing teeth)	
ENDOCRINE					
☐ Excessive thirst, hunger and/or urination	☐ Hair loss	☐ Excess hair growth	☐ Skin changes	☐ Heat or cold intolerance	☐ Changes in perspiration
☐ Changes in menstruation	☐ Night sweats	☐ Irritability	☐ Fatigue	☐ Increased libido	☐ Decreased libido
☐ Poor sleep					

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FEMALE

Menstrual cycle length	☐ Pain before, during or after menses	☐ Clots	What kind of tampons or pads do you use?	How many tampons or pads do you used per day of menstruation?	☐ Do you take any medication relating to your menses including birth control pills?
☐ Do you experience PMS?	☐ Sleep changes	☐ Mood changes	☐ Cold or heat intolerances	☐ Acne	☐ Cravings
If yes specify in the following sections:	☐ Bowel movement changes	☐ Appetite changes	☐ Breast distention	☐ Libido changes	☐ Hot flahes
				☐ Flu-like symptoms	☐ Other
☐ Vaginal discharge	☐ **Are you currently pregnant or trying to become pregnant?**	How many pregnancies have you had?	☐ Are you breasting feeding?	☐ Have you reached menopause?	☐ Do you perform self breast examination?
What was the date of your last mammography?	What was the date of your last bone density test?	At what age did you start menstruating?			

MALE					
☐ Impotence	☐ Testicular pain	☐ Prostate enlargement	☐ Prostate cancer	☐ Do you have problems urinating?	☐ Do you have undiagnosed back pain?
DERMATOLOGY					
☐ Skin lesions or skin cancer	☐ Rash	☐ Changes in moles	☐ Itchiness	☐ Hives	☐ Acne
☐ Hair loss or thinning	☐ Dandruff				
NEUROLOGY					
☐ Seizures	☐ Frequent or recurrent headaches	☐ tingling or Numbness	☐ Fainting	☐ Changes in memory	☐ History of stroke
☐ Localized weakness	☐ History of Concussion	☐ Paralysis	☐ Changes in vision/speech/balance	☐ Tremor or shakiness	☐ Loss of balance
☐ Frequent falls	☐ history of motor vehicle accident				

PSYCHOLOGY					
☐ Depression	☐ Anxiety / Easily stressed	☐ Treated for emotional problems	☐ Thoughts of /attempted suicide	☐ Eating disorder	
☐ Crying spells	☐ Insomnia	☐ Panic attacks			
ALLERGIES					
☐ Asthma	☐ Seasonal allergies	☐ Food intolerances	☐ Food allergies	☐ Environmental allergies	☐ Skin rash
☐ Sensitive to the smell of perfumes	☐ Sensitive to the smell of cigarette smoke	☐ Do you have mold allergy confirmed by a test?	☐ Do you carry an epi pen?	☐ Shortness of breath	☐ Headaches
☐ Runny nose/eyes	☐ Itchy nose/eyes	☐ Chronic sneezing	☐ Chronic Coughing		

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SLEEP PATTERN					
What time do you usually go to sleep?	What time do you wake up?	☐ Wake up in the middle of the night with whole body perspiration	☐ Dream disturbed sleep	☐ Wake up in the middle of the night at around the same time every time, which time:	☐ Wake up due to urge to go urinate
☐ Wake up due to hunger or thirst	☐ Wake up due to urge to go have a bowel movement	☐ Wake up with anxiety and palpitation	☐ Wake up unrefreshed	How long does it take to fall asleep?	☐ Wake up frequently throughout the night
☐ Difficulty waking up in the morning	☐ Do you sleep with your pet(s)?	☐ Do you sleep in a completely dark room?	☐ Any light from underneath the door, radio alarm clock, City light through the window?	☐ Do you snore?	☐ Have you ever been analyzed for sleep apnea?
☐ work out after 6:00 pm?	☐ eat dinner or a snack at least 2 hours prior to going to bed?	☐ read or watch TV in bed?	☐ sleep walk		
MUSCULOSKELETAL					
☐ Back or neck pain	☐ Muscle pain or weakness	☐ Joint pain or swelling or stiffness	☐ History of motor vehicle accident	☐ History of a fall	☐ disc herniation
☐ History of other incidences of physical trauma					

Please feel free to include any other information you feel might be relevant to your medical case.