

Dragonfly Family Health Centre

171 Old Colony Rd. Kanata, ON K2L1M6

Tel: 613-831-2661

www.dragonflynaturopathy.com

Adult Intake Form:

email: _____

Name: _____ Date: 20__/___/___ (i.e.2009/may/9)
Address: _____ Phone - home: (____) ____-____
Work: (____) ____-____
Age: ____ Birthdate: ___/___/___ (i.e. 1970/Jan/11) Cell: (____) ____-____

Marital Status: _____ Name of Spouse: _____

Number of Children & Ages: _____

Occupation(s): _____ Religion/Spiritual Path: _____

Contact in Case of Emergency:

Name: _____ Relation: _____

Phone: (____) ____-____ Office: (____) ____-____ Other: (____) ____-____

Health Care Resources:

Medical Doctor: _____

Office: (____) ____-____ Fax: (____) ____-____

Other Health Care Practitioner: _____

Office: (____) ____-____ Fax: (____) ____-____

Other Health Care Practitioner: _____

Office: (____) ____-____ Fax: (____) ____-____

How did you hear about this clinic? _____ Yellow Pages ____ Superpages ____

Have you ever been treated by a Naturopathic Doctor before? (Please circle) Yes No

If Yes, by whom? _____ When? _____

What for? _____

Please fill in the following pages of questions as best you can. Put an "X" beside ones you wish to discuss. If you need more room use the other side or additional sheets of paper.

A. Primary concern _____

Who diagnosed this condition? _____ When was it diagnosed? _____

How has it been treated until now? _____

B. Medical History

Prenatal Influences (if known, e.g. alcohol, coffee, cigarettes, drugs, stress): _____

Nature of Birth (if known, e.g. trauma, forceps, drugs, natural, etc.): _____

Breast Fed: ____mos. Health as an infant (colic, earaches, development, etc.): _____

Vaccinations: _____ Reactions: _____

Normal Childhood diseases (mumps, measles, chicken pox): _____

Any complications? _____

Chronic problems as a child (lungs, stomach, throat, other): _____

Tonsils out? _____ Age: _____ Complications: _____

Specific teenage problems (eg. acne, weight, development, mono, other) _____

Adult Illnesses:	Age:	How severe (hospitalized?)
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Medications taken (including prescription and over-the-counter drugs, excluding supplements). List what, when, for what, for how long and any reactions experienced.

Have you ever had a nervous breakdown? _____
 If so, when, how severe and what treatment did you receive?

C. Family History

Appearance or parents (build, colouring, hair texture, glasses, eye colour)

Mother: _____

Father: _____

Which side of the family do you take after in physical appearance? _____

Health problems of mother: _____

father: _____

Check any disease which have occurred in your family, who had them and at what age. Specify side of the family.

- | | |
|--|--|
| <input type="checkbox"/> Cancer _____ | <input type="checkbox"/> Kidney Disease _____ |
| <input type="checkbox"/> Diabetes _____ | <input type="checkbox"/> Arthritis _____ |
| <input type="checkbox"/> Mental Illness _____ | <input type="checkbox"/> Anemia _____ |
| <input type="checkbox"/> Tuberculosis _____ | <input type="checkbox"/> Headaches _____ |
| <input type="checkbox"/> High Blood Pressure _____ | <input type="checkbox"/> Alcoholism _____ |
| <input type="checkbox"/> Stroke _____ | <input type="checkbox"/> Ulcers _____ |
| <input type="checkbox"/> Thyroid Problems _____ | <input type="checkbox"/> Anything similar to your own symptoms _____ |

D. Habits

Diet: normal, junk food, vegetarian, other _____

What is an average day's food intake? Include beverages.

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Do you eat quickly? _____ standing up? _____ on the run? _____

at restaurants often _____, if so, what type of restaurants? _____

Supplements taken (vitamins, minerals, herbs, etc.) _____

Exercise: type: _____ amount: _____

Drugs: do you use recreational drugs? _____

If so, what and how often? _____

Cigarettes? _____ How many per day? _____

Alcohol ? _____ How much per week? Beer _____ Liquor _____ Wine _____

Sleep: What are your regular sleeping hours? From _____ to _____

Do you wake refreshed? _____ In what mood do you awaken? _____

Relaxation: What do you do to relax? _____

Have you learned any specific relaxation exercises? _____

Review of symptoms. Check those that apply now or in the past(p). Add any not listed. Use back of page if necessary.

<p>General: ___ height ___ weight ___ changes in wt. energy level: hi med low ___ daily fluctuations ___ fatigue</p> <p>Skin: ___ rash, ___ lumps ___ itching, ___ dryness ___ colour change ___ change in hair ___ change in nails ___ eczema</p> <p>Blood: ___ abnormal blood test ___ bleed/bruise easily ___ anemia ___ allergies</p> <p>Head: ___ headache ___ head injury ___ long labour/forceps at birth</p> <p>Eyes: ___ poor vision ___ glasses/contacts ___ sensitive to light ___ last eye exam ___ pain ___ redness ___ discharge ___ excess tearing ___ double vision ___ glaucoma ___ cataracts ___ infections</p> <p>Ears: ___ poor hearing ___ ringing in ears ___ dizziness ___ earaches ___ infection ___ discharge ___ excess ear wax</p> <p>Nose/Sinuses: ___ frequent colds ___ nasal stuffiness ___ hay fever ___ nosebleeds</p>	<p>Mouth/Throat: ___ cavities/root canals ___ poor gums ___ sore tongue ___ cold/canker sores ___ last dental exam ___ coated tongue ___ hoarseness ___ frequent sore throat ___ bitter taste in mouth</p> <p>Lymph nodes: neck/underarms/groin ___ lumps ___ pain</p> <p>Breasts: ___ lumps ___ pain ___ nipple discharge ___ self examinations</p> <p>Lungs: ___ cough ___ sputum ___ wheezing ___ shortness of breath ___ last chest x-ray ___ difficulty breathing ___ at night</p> <p>Heart: ___ heart problems ___ high blood pressure ___ rheumatic fever ___ swollen ankles ___ chest pain ___ palpitations ___ last ECG/ other tests ___ cholesterol hi/low ___ heart murmurs</p> <p>Urinary: ___ urinations per day ___ urination at night ___ pain ___ blood in urine ___ urgency ___ kidney trouble ___ incontinence ___ infections ___ stones ___ dribbling</p> <p>Endocrine: ___ thyroid trouble ___ heat___cold</p>	<p>Musculoskeletal: ___ joint pains ___ stiffness ___ arthritis ___ bad posture ___ gout ___ backache ___ muscle pain/cramps</p> <p>Circulation: ___ pains in calves after exercise ___ leg cramps ___ varicose veins ___ cold extremities ___ thrombophlebitis</p> <p>Digestion: ___ trouble swallowing ___ heatburn ___ nausea ___ appetite up or down ___ vomiting ___ w/blood ___ indigestion ___ bowel movements/day ___ rectal bleeding ___ change in bowel movements ___ pale ___ black stools ___ w/ undigested food ___ small ___ or thin ___ constipation ___ diarrhea ___ abdominal pain ___ difficulty skipping a meal ___ food intolerance(s) ___ food cravings ___ excessive belching ___ bloating ___ passing gas ___ haemorrhoids ___ jaundice ___ liver or gall bladder trouble ___ hepatitis</p> <p>Nervous System: ___ fainting ___ blackouts ___ paralysis ___ local weakness ___ numbness ___ tingling ___ tremors</p>	<p>Female: ___ age at first period ___ length of cycle ___ duration of periods ___ regular? ___ last menstrual period ___ amount of bleeding ___ between periods ___ after intercourse ___ painful periods ___ age of menopause ___ symptoms ___ post menopausal bleeding ___ discharge ___ itching ___ infections ___ treatments ___ last pap smear ___ # of pregnancies ___ # of deliveries ___ # of abortions ___ complications of pregnancy ___ birth control ___ frequency of intercourse ___ sex drive ___ sexual difficulties</p> <p>Male: ___ discharge from penis ___ sores on penis ___ hernias ___ testicular pains ___ venereal disease ___ treatment ___ masses ___ prostate problems ___ frequency of intercourse ___ sex drive ___ sexual difficulties</p> <p>Mind: ___ nervousness ___ tension ___ mood swings ___ depression ___ lack of concentration ___ fuzziness</p> <p>Emotions: excess anger / sadness / frustration / mania /</p>
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<input type="checkbox"/> sinus trouble <i>Immune:</i> <input type="checkbox"/> allergies <input type="checkbox"/> HIV positive	intolerance <input type="checkbox"/> excessive sweating <input type="checkbox"/> diabetes <input type="checkbox"/> excessive thirst/ hunger/urination	<input type="checkbox"/> memory <input type="checkbox"/> strokes	difficulty feeling or expressing emotions _____ _____ _____
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E. Psychosocial History

List any important life experiences, in chronological order, especially traumatic events.

Age	Event	Comment
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Briefly outline a typical week day. What do you do from waking to sleeping?

Time	Activity	Time	Activity
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Who are the most significant others in your life and what are the challenges in each relationship?

Religious or spiritual beliefs: _____

What is your view of the present and your outlook for the future? _____

How do you feel about yourself? _____

H. Summary

Do you have a preference for the type(s) of naturopathic treatment used?

Are there any treatments you are presently aware of which you would rather use?

Do you have a supportive environment (home/work) for making lifestyle changes?