FAMILY HEALTH CLINIC – Naturopathic & Preventive Medicine

ADULT INTAKE FORM

TODAY'S DATE OR DATE OF FIRST APPOINTMENT _____ /_____ /_____ BIRTHDATE _____ /_____ /_____ AGE: _____
MM DD YYYY MM DD YYYY

FULL NAME _____ PREFERRED NAME _____

GENDER _____ PREFERRED PRONOUNS _____ MARTIAL STATUS _____ CARE CARD # _____

ADDRESS _____ CITY _____ POSTAL CODE _____

HOME PHONE _____ CELL PHONE _____ EMAIL ADDRESS _____

PREFERRED CONTACT METHOD FOR APPOINTMENT REMINDERS: ☐ HOME PHONE ☐ CELL PHONE ☐ TEXT ☐ EMAIL

EMERGENCY CONTACT NAME _____ PHONE _____ RELATIONSHIP _____

FAMILY PHYSICIAN _____ CHIROPRACTOR _____ SPECIALIST _____

OCCUPATION _____ EMPLOYER _____

WHO REFERRED YOU TO THIS OFFICE? _____

PRESENT HEALTH PROBLEMS: LIST YOUR MAIN HEALTH CONCERNS / SYMPTOMS

1) _____ 2) _____ 3) _____

WHAT TREATMENTS HAVE BEEN TRIED? _____

MEDICAL HISTORY: HAVE YOU HAD ANY OF THE FOLLOWING (CHECK)

- ☐ ANEMIA
- ☐ HEPATITIS/LIVER DISEASE
- ☐ HAYFEVER
- ☐ TUBERCULOSIS
- ☐ STOMACH ULCER
- ☐ MEASLES
- ☐ COLITIS
- ☐ BLOOD CLOTS
- ☐ GALLBLADDER PROBLEMS
- ☐ ANGINA/CHEST PAIN
- ☐ POLIO
- ☐ STROKE
- ☐ EPILEPSY
- __ SMOKER? (Y OR N)
- ☐ RHEUMATIC FEVER
- ☐ KIDNEY STONES
- ☐ ASTHMA
- ☐ CANCER OF_____
- ☐ MIGRAINE/HEADACHES
- ☐ MUMPS
- ☐ ARTHRITIS/RHEUMATISM
- ☐ HIVES
- ☐ THYROID PROBLEMS
- ☐ HEART DISEASE
- ☐ DIABETES
- ☐ MENTAL DISORDER: _____
- ☐ ALCOHOL/DRUG ABUSE
- ☐ HEART ATTACK
- ☐ HIGH BLOOD PRESSURE
- ☐ PNEUMONIA
- ☐ BLADDER/VAGINAL INFEC.
- ☐ ABNORMAL PAP TEST
- ☐ PROSTATE PROBLEMS
- ☐ BLEEDING TENDENCIES
- ☐ MONONUCLEOSIS
- ☐ SEXUALLY TRANSMITTED INFECTION (STI)
- ☐ ECZEMA
- ☐ EATING DISORDER
- ☐ DEPRESSION

SURGERIES (YEAR & TYPE) _____

_____

_____

HOSPITALIZATIONS (YEAR & REASON) _____

_____

_____

INJURIES/ACCIDENTS (YEAR & CAUSE) _____

_____

OTHER CONDITIONS _____

FAMILY HISTORY: INCLUDE BLOOD RELATIVES ONLY

Please check box if deceased

FATHER (AGE)* ____ ☐ MOTHER (AGE)* ____ ☐

BROTHERS (AGES)* _____ ☐ SISTERS (AGE)* _____ ☐

HAVE ANY OF THE ABOVE HAD THE FOLLOWING? (CHECK)

- ☐ DIABETES
- ☐ GOUT
- ☐ COLITIS
- ☐ STROKE
- ☐ GALLBLADDER PROBLEM
- ☐ NERVOUS BREAKDOWN
- ☐ BLEEDING TENDENCIES
- ☐ HEART DISEASE
- ☐ ALLERGIES
- ☐ ALCOHOLISM
- ☐ TUBERCULOSIS
- ☐ PSYCHIATRIC ILLNESS
- ☐ HIGH BLOOD PRESSURE
- ☐ STOMACH ULCERS
- ☐ ASTHMA
- ☐ ARTHRITIS
- ☐ CANCER
- ☐ KIDNEY DISEASE

WOMEN ONLY – CHILDBIRTH HISTORY

NUMBER OF CHILDREN ___ AGES _____

NUMBER OF PREGNANCIES ___ NUMBER of DELIVERIES ___

MISCARRIAGES ___ ACCIDENTAL ___ INDUCED ___

COMPLICATIONS _____

BIRTH CONTROL METHODS

IN THE PAST _____

NOW _____

ARE YOU PREGNANT AT THIS TIME? ☐ YES ☐ TRYING ☐ NO

KNOWN ALLERGIES (include medicines, pollens, animals, foods & chemicals): _____

_____

_____

CURRENT MEDICATIONS (list all prescription & over the counter medicines, **vitamins, minerals, herbs** that you take): _____

_____

_____