SHARMILA THARMARJAH

Doctor of Naturopathic Medicine

Naturopathic Intake - Adult

Patient Intake Form

Please take time to fill out the following form. It provides a basis for further questions during your visit and the responses you provide will assist me in understanding your health care needs and goals. All information is for office use only and will be kept confidential.

(Please print clearly)

Name _____ Date _____

Date of birth _____ (M/D/Y) Preferred Pronoun: He She other:__

Address:_____ Apt/unit #_____

City _____ Province _____ Postal Code_____

E-mail Address:_____

Telephone number: Home:_____ Work:_____ Cell:_____

May we leave messages relating to your visits? Y / N Which Phone Number_____

Emergency contact: Name: _____

Phone number(s):_(_____)_____ or_(_____)_____ Relation:_____

Occupation *(Full Time or Part Time)*:_____

Marital Status: [single] [married] [separated] [divorced] other: _____

Children: [yes] [no] If yes, please list ages: _____

How did you hear about the naturopathic services at this clinic? _____

Would you like you receive clinic updates/ special offers/upcoming events? [Yes] [No]

(Your e-mail address is kept strictly confidential)

Extended Health care Insurance Company *(if applicable)*: _____

_ _____

Other health care providers you are seeing:

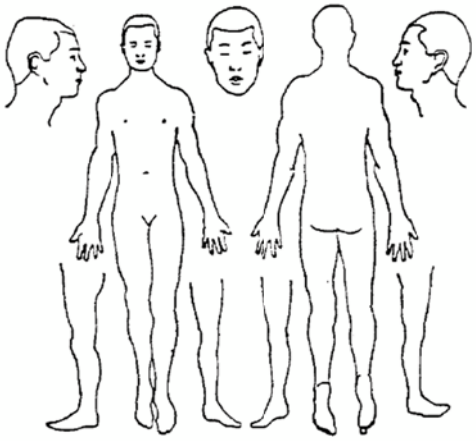
Name:_____	Name:_____ _____	Name:_____
Specialty:_____	Specialty:_____	Specialty:_____
Ph (_____)_____	Ph (_____)_____	Ph (_____)_____
Date of last visit: _____	Date of last visit: _____	Date of last visit: _____

Have you ever consulted *(Please check all that apply):*

☐ Naturopathic doctor ☐ Acupuncturist ☐ Nutritionist ☐ Counsel

Health Goals

What are your **health concerns** and **goals**, in order of importance to you?

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?	**Indicate painful or distressed areas:**
1. **2.** **3.** **4.** **5.**		 *Please provide description of the pain or distress:*

Medical Concern(s): Please refer to the above list of your primary health concerns, in order of importance. Please **describe their onset, severity, location, how long** you have been experiencing them, and any **other useful information** in the space provided below.

1.
2.
3.
4.
5.

If you are a **female**, are you currently **pregnant** or think you may be pregnant? [Yes] or [No]

If yes, 1) week(s) of pregnancy _____ 2) Expected due date: _____

How would you rate your current health? *(Circle one)* Excellent Good Fair Poor

Medical history

Please indicate any serious conditions, illnesses or injuries, and any hospitalization (including type and year of occurrence)

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Do you have any **allergies** (medicines, foods, herbs, drugs, environmental, etc.)?

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

List daily intake of **CURRENT medications** (prescription/over-the-counter) with **reason**/health condition, dosage and # taken/day

1) Name:_____ Reason: _____Dosage: _____

2) Name_____Reason: _____Dosage: _____

3) Name_____Reason: _____Dosage: _____

4) Name_____Reason: _____Dosage: _____

5) Name:_____Reason: _____Dosage: _____

List daily intake of **CURRENT supplements** (vitamins, minerals, herbs, homeopathics, etc) with **dosage** and **# taken/day**

1) _____ 4) _____

2) _____ 5) _____

3) _____ 6) _____

Please list **PAST** prescription medications/natural health products:

_____

_____

Indicate which of the following you have or may have had:

□ Abscess □ Abortion □ Alcoholism □ Anemia □ Anxiety □ Arthritis □ Asthma □ Cancer □ Chicken pox □ Cold Sores □ Depression □ Diabetes □ Eczema □ Emphysema □ Epilepsy □ Fibrocystic breast disease □ Frequent colds □ Gallstones	□ Genital herpes □ Genital warts □ Gonorrhea □ Gout □ Hay fever □ Headaches □ Heart disease □ HIV □ Influenza □ Kidney disease □ Leukemia □ Low/High blood Pressue □ Malaria □ Measles □ Malaria □ Menstrual cramps	□ Mental health issues □ Miscarriage □ Mono □ Multiple sclerosis □ Mumps □ Parasites □ Peritonitis □ Pelvic inflammatory disease □ Pleurisy □ PMS □ Pneumonia □ Prostatitis □ Psoriasis □ Rheumatic fever	□ Skin diseases □ Sinusitis □ Stroke □ Strep throat □ Substance abuse □ Syphilis □ Thyroid conditions □ Tonsillitis □ Tuberculosis □ Warts □ Whooping cough □ Worms

Others: _____

_____

Do you get regular **SCREENING** tests done? (Pap, blood test, prostate, breast, colonoscopy)? **Yes / No**

Any screening test abnormal results found *(if applicable)*? _____ Year: _____

Last time you had **blood work** done? _____

- Any abnormal results in blood work *(if applicable, e.g. High cholesterol, high blood-sugar, etc)*?
  - _____
  - _____
  - _____

Are you currently working with a medical doctor (MD)? □ Yes □ No

List any medical treatments you are undergoing *(if applicable):* _____

_____

Immunizations (include date and if you experienced any adverse effects from them):

_____

Please indicate if you have worked or is currently working with other practitioners (circle all that applies). *If in the past, please indicate below when and duration of treatment.*

[Chiropractor] [Physiotherapist] [Massage therapist] [Psychiatrist] Other: _____

_____ _____ _____ _____

Personal Health Habits

What is your: Height? _____ Weight *(current)*? _____ Max weight?_____ Min Weight?_____
Have you lost any weight lately? □ Yes □ No If yes, how many pounds? _____

Do you frequently take any of the following products? *(please circle all that apply)*

Aspirin	*Tylenol*	*Ibuprofen*	*laxatives*
Cough remedies	*antacids*	*diet pills*	*birth control(pills or implants)*

Antibiotic *(past or current)*: Yes or No Approximate # of prescriptions (*in past 10 years*) _____

How much ***alcohol*** do you consume per week? _____

How much ***tobacco*** do you consume per week? _____

How much ***caffeine*** do you consume per week? _____

Do you use ***recreational drugs?*** □ Yes □ No If yes, what type and how often? _____

Do you **exercise** regularily? □ Yes □ No

- If yes, include type, frequency and duration: _____

Sleep patterns (include usual time to sleep and wake, daytime naps, and any difficulties in falling asleep or staying asleep?) _____

Hours of sleep per night? _____ Do you wake feeling rested? □ Yes □ No

Describe your energy level? _____ Is energy better with sleep? □ Yes □ No

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

Typical diet (usual daily intake):

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks & Drinks: _____

Please list the 5 most **significant**, **stressful events** in your life, starting from the most recent. Do any of these events still affect your life now? If so, please explain.

1) _____Year:___

2) _____Year_____

3) _____Year_____

4) _____Year____

5) _____Year_____

Family History

Indicate which of your close family member/relatives suffer from any of the following conditions. Please use initials: Mother [M], Father [F], Brother [B], Sister [S], Children [C], and Grandparents [G]

Allergies_____ High blood pressure_____

Heart disease_____ Diabetes_____

Cancer_____ Cholesterol_____

Depression_____ Autoimmune conditions_____

Drug/Alcohol abuse_____ Thyroid_____

Mental Illness Other:

Environmental Factor

Where do you work? _____

Are you regularly exposed to animals, smoke or chemicals *(explain)*? _____

What are your hobbies and activities? _____

Describe your work environment? _____

How stressful is your work, or other aspects of your life? How well do you handle these stresses? ___

_____

Describe your home environment? _____

Describe your family and work relationships? _____

How would you describe the emotional climate of your home? _____

What is a typical day like for you? _____

Is there anything that you feel is important that has not been covered? Describe below.

_____

_____

Thank you for taking the time to fill out this form!

Patient Signature: _____ **Date**: _____