



Adult Intake Form

This is a comprehensive and confidential intake form that greatly assists in the understanding of your physical, mental, and emotional health both past and present. This information is necessary to properly assess you as an individual and prepare an optimal treatment plan.

General Contact Information

Name: _____
(Last name) (First name)

(Middle initial)

Age: _____ Gender: M F Date of Birth: ____/____/____
D M Y

Address: _____
(Street) (Apt #)

(City) (Province) (Postal code)

Phone numbers: _____
(Home) (Work) (Cell)

May we leave messages related to your visits on your phone? Y N

Preference (circle all applicable): Home / Work / Cell

E-mail address: _____

Occupation: _____

Emergency Contact: _____
(Name) (Relationship)

(Day phone #)

(Evening phone #)

How did you hear about the clinic? _____

Personal Health Information

What are your most important health concerns/conditions? List as many as you can, in order of importance:

Concern/condition	Diagnosed by	Date
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

What is the main reason for your visit today? _____

What expectations do you have from the visits to this clinic?

Have you tried other conventional or alternative treatments? If so, what were they and what were the results?

Current Medical Information

Primary physician: _____
(Name) (Phone #)

When was your last physical exam? _____

Other healthcare providers? _____

Current Medications (Please include any prescription or non-prescription medications as well as the dosage and frequency of use):

1) _____

2) _____

3) _____

4) _____

5) _____

Current Supplements (Please include all vitamins, herbs, or natural products as well as the dosage and frequency of use):

1) _____

2) _____

3) _____

4) _____

Are you sensitive or do you have an allergy to any of the following (please specify):

Medications: _____

Foods: _____

Environment: _____

Past Medical History

Please list all surgeries, major injuries, accidents or emotional trauma that you have sustained and the year in which they occurred:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____

Past Medications/Supplements and their purpose:

- 1) _____
- 2) _____
- 3) _____

How many times have you been treated with antibiotics? _____

Which of the following illnesses and conditions have you had (past or present)? Circle all that apply.

Asthma	Heart disease	Cancer	Chest pain	Depression
Malaria	Hay fever	Miscarriage	Arthritis	Gonorrhea
Peritonitis	Alcoholism	Skin disease	Mononucleosis	Herpes
Chicken pox	Scarlet fever	Rheumatic fever	Hypothyroidism	Kidney disease
Acne	Crohn's disease	Psoriasis	Warts	Shingles
Epilepsy	Irritable Bowel Syndrome	Eczema	Lupus	Chronic Fatigue Syndrome
Diabetes	Diverticulitis	Osteoporosis	MS	Hepatitis
Gout	High blood pressure	Gall stones	Mumps	Prostatitis
Sinusitis	Hernia	Heart problems	Sexually Transmitted Infection	Tuberculosis
Stroke	Constipation	Eating disorder	HIV	Cushing's disease
Colitis	Hemorrhoids	Bipolar disorder	Wilson's disease	Hyperthyroidism (thyroiditis)
Migraines	Ulcers	Schizophrenia	Infertility	Candida (yeast)

Family History

Please list approximate ages and health status of your immediate family.

Relationship	Age (if living, or age when deceased)	Health concerns or cause of death
Mother		
Father		
Sister(s)		
Brother(s)		
Paternal Grandfather		
Paternal Grandmother		
Maternal Grandfather		
Maternal Grandmother		

Are there any medical conditions that run in your family? _____

Personal Health Status

How would you rate your general state of health?

Excellent Good Average Fair Poor

Rate your energy level: low 1 2 3 4 5 6 7 8 9 10 high

Rate your stress level: low 1 2 3 4 5 6 7 8 9 10 high

Current weight: _____ lbs Weight one year ago: _____ lbs Max weight: _____ lbs

When did you reach this weight? _____ Height: _____

Average Daily Food Intake

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

Any foods you crave? _____

Any foods you have an aversion to? _____

Are you satisfied with your present diet? If no, why? _____

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

Women's Health

Age of first menstrual period: _____ How long is your typical menstrual cycle? _____

When was your last menstrual period? _____

Do you experience any of the following?

Heavy flow	Clotting	Light flow
PMS	Vaginal discharge	Pain during intercourse
Vaginal itching	Vaginal Odour	Vaginal dryness
Abnormal Pap test	Bleeding between periods	Breast tenderness

If you circled PMS, which apply? Pain Cramping Cravings Mood swings Headaches Bloating Water retention Breast tenderness Irritability Fatigue Insomnia Anxiety Others: _____

Are you pregnant? Y N Any problems with fertility? Y N Not sure

Number of pregnancies _____ Number of miscarriages _____

Number of births _____ Number of abortions _____

Have you ever used (or are you currently using) birth control? Y N

Type and duration of use _____

Date of last Pap test _____ Was it normal? _____

Have you had a hysterectomy? Y N

Do you perform monthly self breast examinations? Y N

When was your last breast exam? _____

Do you receive regular mammograms? Y N

Men's Health

Please circle any past or present health concerns.

Prostate problems	Swelling/lumps in testicles	Painful erection	Discharge from penis
Infertility	Difficulty maintaining/achieving erection	Difficulty/premature ejaculation	Painful/difficult urination

Are you currently sexually active? Y N

If yes, what type of contraception do you use? _____

Lifestyle

Do you exercise? Y N If yes, how often and what type? _____

Do you smoke? Y N If yes, how often and what form? _____

Do you use drugs? Y N If yes, how often and what type? _____

Do you drink alcohol? Y N If yes, how often and what type? _____

Do you drink coffee? Y N If yes, how often and what type? _____

Do you sleep well? Y N Do you fall asleep easily? Y N

Average amount of sleep? _____ Do you wake rested? Y N

Dental Health

Current dentist: _____

Last dental check-up: _____ Last cleaning: _____

Were your wisdom teeth removed? Y N

Any fillings? Y N Type? _____

Any trauma to the teeth or jaw? Location? _____

Are your teeth hot or cold sensitive? Y N

Any orthodontic work done (ie. Braces)? Y N Type? _____

Information About You (Mental/Emotional Health)

In your estimation, tell me who you are? Write a short description of yourself – personality, strengths, weaknesses, etc.

What do you love to do?

What do you really dislike doing?

Do you have any fears? Do they interfere with your everyday life?

Have you experienced any major grief or disappointments – past or present?

Any known sexual or physical abuse?

If you are sexually active, how would you describe your sex life? Are you dissatisfied with any aspect?

How would describe the quality of your personal relationships?

Do you have children? If so, please list their name, age, and any other information that you feel is relevant.

If you were to change one thing about yourself, what would that be?

Are you an active participant in a religion? If so, which religion and how important is this to your life.

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

Thanks for taking the time to complete this intake form! The answers you provide allow me to have a better understanding of who you are and what your main goals and health concerns are. **Please fax, mail, or scan to e-mail this form to the Marda Loop Naturopathic and Wellness Clinic at least 48 hours before your appointment** to ensure I have time to go over what you have written. If sending a copy via e-mail the addresses are as follows: *patientcare@mardaloopwellness.com*.