131 Union Street East,
Suite #103
Waterloo, ON
N2J 1B8

The Natural Way
HEALTH CLINIC

(T) 519-772-2116
(F) 886-731-5603
www.thenaturalwayclinic.com

NATUROPATHIC INTAKE FORM

A Multidisciplinary approach to medicine is holistic and seeks to understand all factors that may be affecting your health. Please answer the following questions to the best of your ability.

Name: _____ Date: _____
Date of Birth: _____ (m/d/y) Age: _____ Sex: Male / Female
Mailing Address: _____
City: _____ Postal Code: _____
Email: _____
Telephone: May we leave a message?
Home/Eve: (____) _____ YES / NO
Work/Day: (____) _____ YES / NO
Cell: (____) _____ YES / NO
What is the best way to contact you? HOME / WORK / CELL

☐ **I give my consent to include my e-mail address on the clinic newsletter mailing list**

How did you hear about The Natural Way/ Who may we thank? _____

Occupation _____
Ethnic Background _____
Marital Status _____
DO YOU HAVE DIFFICULTY CLIMBING STAIRS? YES / NO

EMERGENCY CONTACT

Name: _____
Phone: _____
Relation: _____

PREVIOUS CARE

Have you seen a Naturopathic Doctor before? YES / NO
If **yes**, was it a positive experience? YES / NO
Please explain: _____
Have you had chiropractic treatment before? YES / NO
If **yes**, was it a positive experience? YES / NO
Please explain: _____
Are you interested in preventative maintenance care? YES/ NO

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FOR WOMEN:

Is it possible that you are currently pregnant? YES/NO
Are you currently breastfeeding? YES/NO

HEALTH PROFESSIONALS

Please list all health professionals from which you currently receive care (ex. Medical Doctor, Specialists, Physiotherapist, Massage Therapist, Naturopathic Doctor, and Chiropractor).

In addition, please circle YES or NO, beside each practitioner, indicating your permission for us to contact each practitioner, as necessary, regarding your case.

Permission for Exchange of Information

1. Name: _____ YES / NO
   Address: _____
   Phone: _____
   Fax: _____
   Type of Practitioner: _____

2. Name: _____ YES / NO
   Address: _____
   Phone: _____
   Fax: _____
   Type of Practitioner: _____

3. Name: _____ YES / NO
   Address: _____
   Phone: _____
   Fax: _____
   Type of Practitioner: _____

4. Name: _____ YES / NO
   Address: _____
   Phone: _____
   Fax: _____
   Type of Practitioner: _____

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PRESENT HEALTH STATUS

***Please rate your overall, general health:** (circle a number)

0 1 2 3 4 5 6 7 8 9 10

Unhealthy/Ill Very Healthy

CHIEF COMPLAINT

What are your health concerns? (Please list in order of importance):

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

What other types of treatment or health-care practitioners have you consulted for treatment of these health issues?

_____

_____

List any lab work, x-rays, or consultations with specialists related to your condition (include dates): _____

_____

Is your current condition the result of a motor-vehicle accident? YES / NO

Is your current condition the result of a work-related injury? YES / NO

Please indicate if your current complaint has significantly affected your ability to perform any of the following activities of daily living:

□ Sleeping
□Travel/Driving
□Washing
□Dressing
□Preparing Meals
□Care-giving
□Cleaning/Household Chores
□Duties of Employment
□Recreation/Social Activities

MEDICATIONS

List any **prescribed** medications you are <u>currently</u> taking along with doses and the date this medication was started:

<u>Name of Medication</u>:	<u>Date started:</u>	<u>Dose:</u>
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

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List any **over-the-counter** medications, dietary supplements, or herbs you are currently taking:

Name:	**Date started:**	**Dose:**
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Do you use any of the following on a regular basis?

- □ Laxatives
- □ Antacid
- □ Steroids
- □ aspirin/ibuprofen
- □ Thyroid medication
- □ Sedatives
- □ Diet pills
- □ Cortisone
- □ Sleeping pills
- □ Appetite suppressants

How many times, approximately, have you been treated with antibiotics? _____
How long ago was the last course? _____

Please List Any Drug, Food, or Environmental Allergies:
_____

PAST MEDICAL AND HEALTH HISTORY

Please list any past serious injuries or illnesses, including when they occurred and any complications that you may have experienced:
_____
_____

Please list any hospitalizations or operations, including why, when they occurred and any complications that you may have experienced:
_____
_____

Have you ever experienced, or are you currently experiencing any of the following:

Night sweats	YES / NO
Significant or unexplained weight changes	YES / NO
Pain that awakes you from sleep	YES / NO

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Have you had any of the following illnesses, as a child or adult?

□Chicken Pox
□Measles
□Mumps
□Rubella
□Whooping Cough
□Scarlet Fever
□Roseola
□Polio
□Meningitis
□Mononucleosis
□Tuberculosis
□Strep throat
□Frequent Ear Infections
□Rheumatic Fever

FAMILY HEALTH HISTORY

Please indicate which family members (parents, siblings, grandparents), if any, have had or have the following conditions:

□ Diabetes _____
□ Heart Disease _____
□ High Blood Pressure _____
□ High Cholesterol _____
□ Stroke _____
□ Cancer _____
□ Seizures _____
□ Kidney Disease _____
□ Thyroid Dysfunction _____
□ Asthma _____
□ Allergies _____
□ Arthritis _____
□ Autoimmune disease _____
□ Osteoporosis _____
□ Depression _____
□ Schizophrenia _____
□ Alcohol/Drug abuse _____
□ Other Mental Illness _____
□ Other _____

ROLES/RELATIONSHIPS

Number of children? _____ Ages _____ How many at home? _____

Difficulties/Problems? _____

How many people live in your household? _____

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Social roles (please check all roles that apply to you):

_____ Friend _____ parent _____ employer _____ employee

_____ spouse _____ caretaker _____ child _____ volunteer

Date of last physical exam: _____

Please circle (o) any condition/symptom currently causing you problems. Please <u>underline</u> conditions/symptoms that were a problem in the past:

GENERAL SYMPTOMS
Loss of consciousness
Blackouts
Headache
Fever
Sweats
Fainting
Dizziness
Clumsiness
Convulsions
Loss of sleep
Numbness
Pain
Tingling
Nervousness
Weight loss
Eating disorder
Anemia
Other: _____

EMOTIONAL
Depression
Anxiety
Mood swings/irritability
Phobia
Alcohol/Drug Abuse

MALE REPRODUCTIVE
Testicular mass
Prostate trouble
Hernia

FEMALE REPRODUCTIVE
Painful menstruation
Excessive flow
Hot flashes
Irregular cycle
Cramps/backache
Vaginal discharge/itching
Yeast infections
Ovarian cysts/PCOS
Endometriosis
Fibroids
Swollen breasts
Lumps in breasts
Nipple discharge
Other: _____

G.U.
Trouble urinating
Frequent urination
Blood in urine
Kidney infection
Bed wetting
Sexual difficulties
Other: _____

GASTROINTESTINAL
Bloating
Poor appetite
Indigestion
Heart burn/acid reflux
Excessive hunger
Belching or gas
Bad breath
Nausea
Vomiting blood
Abdominal pain/cramps over stomach
Constipation
Diarrhea
Hemorrhoids
Gall bladder trouble
Ulcer
Diabetes
Other: _____

CARDIOVASCULAR
High cholesterol
High blood pressure
Low blood pressure
Bleeding disorder
Pain over heart
Stroke
Varicose veins
Swelling of ankles
Poor circulation
Heart or blood disease
Angina
Palpitations

E.E.N.T
Blurred vision
Impaired vision
Double vision
Eye redness
Eye pain
Eye itching
Eye discharge
Eye dryness
Floaters
Deafness
Earache
Ringing/buzzing in ears
Ear discharge
Wax build-up
Frequent ear infections
Allergies
Sleep apnea
Post nasal drip
Loss of smell
Nasal polyps
Frequent colds
Frequent sore throats
Sinus infection
Enlarged glands/nodes
Enlarged thyroid
Speech problems
Difficulty swallowing
Cavities
Gum problems
Other: _____

MUSCLES & JOINTS
Stiff neck
Back ache
Swollen joints
Foot trouble
Shoulder pain

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Other: _____

Arm/forearm pain
Elbow pain
Wrist pain
Hand pain
Arthritis
Weakness
Other: _____
Past ECG/other heart tests

RESPIRATORY
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Chest pain
Difficulty breathing
Other: _____

SKIN
Rashes
Itching
Dryness
Eczema
Psoriasis
Hives
Boils
Dryness
Lumps
Hair loss
Nail changes
Other: _____

Please provide information regarding the following health tests, if applicable:

Test	Date	Normal	Abnormal
Blood Pressure			
Bone Density			
Cholesterol			
Colonoscopy			
MRI/CT Scan			
Mammogram			
Nerve Conduction Studies			
PAP Test			
Prostate Exam			
Testicular Exam			

LIFESTYLE

*Do you currently smoke cigarettes? YES / NO
If **yes,** for how many years? _____
If **yes**, how many packs per day? _____
If **yes**, have you ever stopped in the past? YES / NO
If **no**, have you ever smoked cigarettes in the past? YES / NO
Are you regularly exposed to tobacco smoke or other environmental toxins at home?
Please Describe: _____

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Do you use any form of Recreation drug? YES / NO
If **yes,** please indicate which drug and how often: _____

Do you drink alcoholic beverages? YES / NO
If **yes,** please estimate how much: _____ wine (glasses/wk); _____ beer (glasses/wk);_____ liquor (glasses/wk)
Do you drink caffeinated beverages? YES / NO
If **yes,** please indicate the equivalent number of regular sized cups per day:
_____ coffee (cup/day); _____ tea (cup/day); _____ cola (glasses/day)

NUTRITION

Do you consider yourself: ___ Overweight ___ Underweight ___ about right
What is your ideal weight? _____
Has your weight changed recently? YES / NO
Do any of the factors listed below make it difficult for you to eat right (please check all that apply)?

___ eating out
___ dislike recommended foods
___ Moods
___ taking large portions
___ Someone else cooks
___ Frequent snacking
___ I need information on healthful eating

Do you eat at least two fruits and two vegetables each day? YES / NO

Are there any foods which you exclude from your diet? YES / NO

Please Explain: _____

How much water do you consume per day? _____

What is the primary source of your drinking water (bottled, tap, filtered, well, etc)?
_____

ACTIVITY/EXERCISE

How active are you? _____ Very _____ Moderately _____ Sedentary

Do you have any physical problems that limit your activity? YES / NO
If **yes**, please describe: _____

***Do you regularly do aerobic exercise** (ex. walking, swimming)? YES /NO
If **yes**: ***sessions/week:** _____***minutes/session:** _____

***Do you regularly do muscle toning exercises** (ex. Weights)? YES / NO
If **yes**:***sessions/week:** _____

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If you are not yet engaged in a routine exercise program, are you interested in starting? YES / NO

SLEEP/REST

Number of hours of sleep per night? _____

Do you nap? YES / NO If **yes,** how many hours do you nap? _____

Do you have difficulty falling asleep? YES / NO

Do you wake up during the night? YES / NO If **yes**, how often? _____

Do you feel rested on waking? YES / NO

Do you have problems with insomnia? YES / NO

MENTAL HEALTH

Do you experience any of the following feelings more often than most people? (Check all that apply)

_____ fear	_____ anxiety	_____ isolation
_____ guilt	_____ shame	_____ lack of control
_____ helplessness	_____ hopelessness	_____ hostility
_____ sadness	_____ anger	_____ depression

EMOTIONAL SUPPORT

Have you ever sought counseling or therapy to help you cope? YES / NO
If **yes**, please indicate type of counselor/time period: _____

Can you count on anyone to provide you with emotional support? YES / NO
If **yes,** check all that apply:

_____ spouse _____ family _____ friend _____ religion/spiritual _____ pet _____ other

STRESS

***Do you feel you have an excessive amount of stress in your life? YES / NO**

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What is your perception of daily stressors which interfere with your life?
(Please circle the number corresponding to each, 0=No stress and 10=Worst stress.)

Work:	0	1	2	3	4	5	6	7	8	9	10
Family:	0	1	2	3	4	5	6	7	8	9	10
Social:	0	1	2	3	4	5	6	7	8	9	10
Finances:	0	1	2	3	4	5	6	7	8	9	10
Health:	0	1	2	3	4	5	6	7	8	9	10
Living Situation:	0	1	2	3	4	5	6	7	8	9	10
Neighbourhood:	0	1	2	3	4	5	6	7	8	9	10
Other: _____	0	1	2	3	4	5	6	7	8	9	10

***Do you meditate or practice a relaxation technique? YES / NO**

If **yes**: ***Sessions per week: _____ Minutes per session: _____**
Please check all those that apply:
_____ Yoga _____ Imagery _____ abdominal breathing _____ Tai Chi
_____ Meditation _____ Prayer _____ Progressive muscle relaxation
_____Other

VALUES AND BELIEFS

Are there religious or spiritual practices that are meaningful to you? YES /NO
If **yes,** please describe: _____

CONTEXT OF CARE

Treating illness and maintaining health does not occur overnight and without commitment to making lifestyle changes and following treatment protocols. How would you describe your level of commitment at this time?

(0=not committed, 10=fully committed)
0 1 2 3 4 5 6 7 8 9 10

GOALS

What goals do you hope to achieve while receiving treatment?

1._____

2._____

3._____

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Is there anything else that you would like to mention that has not been covered or feel it is important for me to be aware of?

_____

_____

_____

By signing this form, I certify that all of the information provided herein is complete and accurate to the best of my knowledge. If there are any changes to this information I will notify The Natural Way Health Clinic in a timely manner. I give permission to be contacted by The Natural Way Health Clinic as indicated in this form and for messages to be left at the indicated numbers. I give permission for an exchange of medical information to occur with those practitioners indicated within this form. I give permission for exchange of medical information to occur with other practitioners of The Natural Way Health Clinic, as needed for the purpose of consultation.

Please list exceptions: _____

Name of Patient or Guardian: _____

Signature: _____ **Date:** _____

Doctor : _____ License# : _____

Signature:_____ Date: _____