Holistic Clinic
Integrated Health Care

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Naturopathic Adult Intake

PATIENT INFORMATION Today's date (day/mo/yr):_____/_____/_____

Name: _____Email:_____

Date of birth (day/mo/yr):_____/_____/_____ Sex: M / F

Address with postal code: _____

Tel(home): (_____) _____ (work): (_____) _____

Emergency contact: _____ Relationship: _____

Tel(home): (_____) _____ (work): (_____) _____

Medical doctor: _____ MD Tel: (_____) _____

Other healthcare providers: _____

How did you hear about D. Korah, ND? Referral from: _____ Yellow pages _____
naturopathic-doctor.ca _____ holisticclinic.ca _____ Specify other: _____

Optimal health is only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty in completing this confidential overview will greatly assist my understanding of your healthcare needs and desires.

HEALTH INFORMATION

What is your main health concern? _____

_____

_____

Please list any other health concerns (physical, emotional, or mental) in order of importance.

1. _____
2. _____
3. _____

If you are female, are you currently pregnant? Y / N

How do you rate your overall health? Poor Fair Good Excellent

How do you rate your overall energy? Poor Fair Good Excellent

MEDICATIONS

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medication	Dose/day	How long?	Medication	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Please list all current vitamins/minerals, herbs, or homeopathics, the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Supplement	Dose/day	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

How many courses of antibiotics have you had in the past 10 years? _____

Have you ever had a bad reaction to any medication? Y / N

MEDICAL HISTORY

Indicate if you had any of the following childhood illnesses (circle):

Asthma	Measles	Rheumatic fever
Chickenpox	Mumps	Scarlet fever
Eczema	Polio	Whooping cough
Frequent ear infections or colds	Rubella(German measles)	Other: _____

Immunizations (Check ✓)

□ DPT	□ Hemophilus influenza B	□ Hepatitis A	□ Hepatitis B
□ Flu shot	□ Tetanus Booster	□ MMR	□ Polio
□ Smallpox	□ Chicken Pox	□ Other: _____	

Any adverse reactions to vaccinations? Y / N. If yes, explain. _____
_____

Please list (with approximate dates) any serious conditions, illnesses or injuries, and any hospitalizations.

_____
_____
_____

Family History

Please indicate whether any of your family members have, or have had the following:

	Relative		Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart disease	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	

LIFESTYLE FACTORS

Please list any dietary restrictions _____
Are you exposed to significant tobacco smoke? Y / N
Are you frequently exposed to animals? Y / N
Are you regularly exposed to toxins or other hazards? Y / N. If yes, explain. _____
_____
_____

Please list all allergies (food, environmental, or medications). _____
_____
_____
_____

Do you exercise? Y / N
What type of exercise and how often? _____

What do you do for recreation and relaxation? _____
_____

Occupation: _____

Marital status: _____ Number of children: _____

Describe the emotional climate of your home. _____
_____

Rate your stress level (circle): Low Average High Unbearable

Which factors most contribute to your stress? (circle)
Health Work Money Family Marriage Other: _____

What are your spiritual or religious roots? _____
Are you an active participant with this or another group? Y / NIn your everyday life, your present faith/spiritual practices are:
Not very important Somewhat important Very important

Please circle any of the following that you use.

Alcohol	Diet pills
Antacids	Laxatives
Antibiotics	Pain relievers
Aspirin	Recreational drugs
Appetite suppressants	Sleeping pills
Birth control pills	Thyroid medication
Caffeine	Tobacco
Cortisone	Tranquilizers

WOMEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, Pap)? Y / N
Date of last Pap?(month/yr) _____/_____ Have you ever had an abnormal Pap? Y / N

Age of first period? _____ Is your period regular? Y / N

Length of monthly cycle (days)? _____ Average length of period or flow (days)? _____

Do you experience PMS? Y / N Are you menopausal? Y / N. If yes, age of last period____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Have you ever had a sexually transmitted disease? Y / N

Number of pregnancies? _____ Births? _____ Miscarriages? _____ Abortions? _____

Have you had any of the following concerning your breasts?(circle)
Pain Lumps Infections Cysts Nipple discharge

Do you experience vaginal infections? Never Rarely Frequently
Do you experience bladder infections? Never Rarely Frequently

Do you have any sexual problems or concerns? Y / N. If yes, explain. _____
_____
_____

MEN'S HEALTH

Do you get regular screening tests done by another doctor (blood work, prostate examination)? Y / N
Date of last prostate examination?(month/yr) _____/_____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N
Current forms of contraception? _____

Do you have difficulty urinating completely? Y / N
How many times do you get up from your sleep to go to the bathroom at night? _____

Have you had any of the following?(circle)
Testicular pain Hernia STDs Discharge Sores

Do you have any sexual problems or concerns? Y / N. If yes, explain. _____
_____
_____

REVIEW OF SYSTEMS

Please **circle** if you are **currently** experiencing any of the following or write a **P** if you experienced it in the **past**.

General symptoms
Headache
Head injury
Fever
Chills
Sweats
Dizziness
Fainting
Loss of sleep
Fatigue
Nervousness
Loss of weight
Numbness or pain in arms/legs/hands
Allergy
Convulsions

Skin
Hives or allergy
Acne or skin eruptions
Itching
Bruises easily
Dryness
Boils
Varicose veins
Sensitive skin
Change in mole

Kidneys & Reproduction
Inability to control urine
Frequent urination
Painful urination
Blood in urine
Pus in urine
Kidney infection
Kidney stones
Prostate trouble
Sores on genitals

Eyes,Ears,Nose,Throat
Dental decay
Gum trouble
Frequent colds
Enlarged thyroid
Tonsillitis
Sore throat
Hoarseness
Enlarged glands
Glaucoma
Failing vision
Cataracts
Eye pain
Ear discharge
Deafness
Ear ache
Nasal drainage
Nose bleeds
Nasal obstruction
Sinus infection
Hay fever
Mercury tooth fillings

Muscle & Joint
Stiff neck
Back pain
Muscle weakness
Swollen joints
Painful tailbone
Foot trouble
Pain in shoulders
Hernia
Spinal curvature
Faulty posture
Arthritis
Fracture/dislocation

Cardiovascular
Low blood pressure
High blood pressure
Previous heart stroke
Hardening of the arteries
Swelling of the ankles
Poor circulation
Paralytic stroke
Irregular heart beat
Shortness of breath
Chest pain

Gastrointestinal
Excessive thirst
Excessive hunger
Belching
Gas (flatulence)
Nausea
Vomiting
Vomiting of blood
Abdominal cramps
Constipation
Diarrhea
Colon trouble
Hemorrhoids (piles)
Intestinal worms
Liver problems
Gallbladder problems
Jaundice
Colitis

Respiratory
Asthma
Chronic cough
Spitting up phlegm
Spitting up blood
Difficult breathing

What are your treatment goals and expectations? _____
_____
_____
_____

Is there anything else that you feel has not been covered? _____
_____
_____
_____

Thank you very much for taking the time to complete this form. It will greatly assist in the formulation of a treatment protocol specific to your healthcare needs.