Naturopathic Intake Form
Adult Male

Holistic Clinic
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Please bring this fully completed form to your first visit

Name: _____ **Date:** _____

Address: _____
(street, apartment number)

_____
(city, town) (province, state) (postal code, zip code)

Telephone Number (residence)_____(work)_____

Referred by_____

Family Medical Doctor_____

Chiropractor_____

Other Primary Care Givers_____

Other Naturopathic Doctors consulted_____

Nearest Relative_____ **Their Telephone Number**_____

Secondary Insurance Company (if naturopathic coverage provided)_____

The following information is confidential and will only be released if authorized to do so.

Personal Profile and Health History

Age:_____ Gender:_____ Marital Status:_____

Height:_____ Present weight:_____ Goal (normal) Weight_____

If your present weight is different than your desired weight, how long has it been since you were your normal or goal weight? _____

Name of Spouse (if applicable):_____

How long have you been married? _____ Is this your first marriage? Yes____ No_____

If this is not your first marriage, how many times (including this marriage) have you been married?_____

Number of Dependents (if applicable):_____

Occupation (Nature of Work): _____

Number of hours worked in average work week:_____

Educational Backround:_____

What hobbies do you have:_____

Diet: Non Vegetarian_____ Vegetarian_____ Vegan_____ For how long?_____

Known Food Allergies/Intolerance: _____

Known Environmental Allergies/Sensitivities:_____
_____

What is your primary health concern? _____
_____
_____
How long have you had this condition? _____
What is your medical diagnosis? _____
Name of physician who made the diagnosis?_____
When was the diagnosis made?_____
What specialist have you seen? _____
_____
How has this condition been treated until now?_____
_____
_____

Additional Health Concerns and Health Goals

What else would you like to see changed in your health? List all other health concerns in order of importance to you. Indicate the month and year each particular health concerned started if possible. Also list any specific health goals you would like help with. If you need more space, please use the back of the form or add pages.

	Health Concern/Goals	Month/Year	Present Treatment/Comments
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			

How long has it been since you experienced excellent health?_____

Please give a detailed history of your primary health concern from when you were first aware there was a health problem through to the present. Include pertinent dates.

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Can you trace the origin of the present illness to any particular circumstances, accident, illness, incident, mental upset or unusual stress in you life? If yes, please explain. _____

_____
_____
_____
_____

Every disease, serious illness, accident, toxic exposure, physical or emotional trauma leaves its mark and remains as a weak point in our body's system. Naturopathic medicine takes into account details of the past and will work to eliminate these weak points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken. The time you take now will benefit you in the long run.

In the lists below, check all major illnesses that you have experienced.

Measles (Rubeola)		Irritable Bowel Syndrome		Human Papillovirus(HPV)		High Blood Pressure	
German Measles (Rubella)		Stomach/Duodenum Ulcers		Chlamydia		Low Blood Pressure	
Chicken Pox		Colitis		Syphilis		Fainting	
Mononucleosis		Diverticulitis		HIV		Heart Problems	
Mumps		Hiatal Hernia		Genital Herpes		Palpitation	
Whooping Cough		Constipation		Genital Warts		Circulation Problems	
Scarlet Fever		Crohn's Disease		Gonorrhea		Varicose Veins	
Polio		Appendicitis		Spleen Disease		Anemia	
Reye's Syndrome		Rheumatoid Arthritis		Hypoglycemia		Raynaud's Disease	
Worms/ Parasites		Osteoarthritis		Jaundice		Platelet Disorders	
Cholera		Rheumatism		Hepatitis		Miscarriage	
Malaria		Back pain/Sciatica		Liver Disease		Abortion	
Food Poisoning		Fibromylagia		Pancreatic Disease		D and C	
Typhoid		Gout		Bladder Problems		Gestational Diabetes	
Diarrhea		Strep Throat		Prostate Problems		Uterine Prolapse	
Dysentery		Sinusitis		Diabetes		Preeclampsia	
Acne, Boils, Impetigo		Allergies (Environmental)		Gall Bladder Disease		Other Pregnancy Related Illness	
Carbuncles, Ringworm		Hay Fever		Eye Problems		Fibrocystic Breast Disease	
Fungus		Bronchitis		Kidney Problems		PMS	
Scabies		Pneumonia		Cushing's Disease		Uterine Fibroids	
Shingles		Asthma		Addison's Disease		Endometriosis	
Poison Ivy		Pleurisy		Hypothyroid		Ovarian Cysts	
Eczema		Tuberculosis		Hyperthyroid		Vaginitis (recurrent)	
Keloids		Malnutrition		Eating Disorder		Painful Periods	
Psoriasis		Rickets		Schizophrenia		Infertility	
Warts		Osteoporosis		Bipolar Disease		Migraine Headaches	
Herpes, Urticara		Hemochromatosis		Clinical Depression		Dizziness	
Ulcers		Wilson's Disease		Suicidal Tendencies		Numbness	
Skin Cancer		Chronic Fatigue		Multiple Sclerosis		Cramps	
		Environmental Illness		Lupus		Epilepsy	
Cancer specify type:		Candida(yeast syndrome)		Myasthenia Gravis		Meningitis **Other**:	

In the list below, check all surgeries, accidents or traumatic events you have experienced

Surgeries: (check)	__	**Accidents:**	**Trauma: (check)**	__
Tonsils	__		Serious shock	__
Adenoids	__	Any major accident or injury	Serious grief	__
Abdomen	__	to the body or head:_____	Major	__
Heart	__	_____	Disappointments	__
Appendix	__	_____	Severe fright	__
Hernia	__	_____	Nervous Breakdown	__
Hemorrhoids	__		Period of stress	__
Joint Replacement	__	Any occasion of unconsciousness:	Overload	__
Kidney Stones	__	_____		__
Gall Stones	__	_____	Briefly Describe:___	__
Uterus	__	_____	_____	
Penis	__		_____	
Prostate	__	Any hemorrhage or major	_____	
Hydrocele	__	Bleeding from any part of the	_____	
Cataract	__	Body:_____	_____	
Other:	__	_____	_____	
	__	_____	_____	
Was the anesthesia:	__		_____	
Local/General (circle)				

Please list all surgeries, illnesses, accidents, and traumatic events noted that required treatment:

Diseases, Surgeries, Accidents	Age	Duration	Complete Recovery?	Treatment (including medications)

Vaccinations:

Type	Small pox	Polio	Meningitis	MMR	DPT	other
How many times						

Type	BCG	Typhoid	Tetanus	Hepatitis	Flu	Hib	Cholera
How many times							

Was there any serious reaction to any of the above vaccinations? (please explain)

_____

_____

Dental Work

How many silver amalgam fillings do you have?_____ How many root canals?_____

Family History

Please put an "L" for living and "D" for deceased, and present age or age at the time of death.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			

Relationship	Diseases Suffered
Paternal Uncles	
Paternal Aunts	
Maternal Uncles	
Maternal Aunts	
Brother/Sister (1)	
Brother/Sister (2)	
Brother/Sister (3)	
Brother/Sister (4)	
Brother/Sister (5)	
Brother/Sister (6)	

What is your position in the family? (oldest, middle, youngest)_____

Briefly describe the nature of your relationship with your parents:(as a child and an adult)
_____
_____

How is the health of your spouse?_____

Number of children living and deceased: Living_____ Deceased_____
State cause(s) of death_____

Personal Habits and Lifestyle

How many cups or glasses do you drink on average per day of the following?
Coffee_____ Black Tea_____ Green tea _____Water_____ Milk 2%_____
Skim Milk_____Fruit Juice _____ Soft Drinks (diet) _____ Soft Drinks (reg)_____
Vegetable Juice_____ Herbal Tea_____ Beer_____ Wine_____ Liquor_____

What is the source of your drinking water?
Tap (city) _____ Well_____ Bottled (spring) _____ Filtered_____ Distilled_____

Do you use tobacco products? Y/N
If yes, please check the products you use and indicate on the line beside them how often you use them. Cigarettes_____ Cigars_____ Chewing Tobacco_____ Snuff_____
Have you smoked in the past? Y/N What did you smoke?_____
If yes, for how long? _____ How many per day?_____
Does anyone in your household smoke? Y/N

Have you ever used nonprescription, mood altering drugs ("recreational" drugs)? If yes, please indicate the type, frequency and duration of use._____
_____
_____

Do you regularly use (check):Laxatives___Sleeping Pills___Antacids___Pain Killers___

If so, please indicate the type, frequency and amount:_____

How frequently do you have a bowel movement?_____ Daily or _____Weekly

Have you ever had a problem with an addiction? If yes please specify.
Food_____ Alcohol_____ Drugs_____ Other_____

How many hours of sleep do you get on average?_____

Do you feel refreshed in the morning?_____

How many hours do you work each day?_____

Do you often feel overworked?_____

What do you do for exercise? (indicate frequency, intensity and duration)_____
_____
_____

What do you do for recreation?_____
_____

When was your last vacation?_____

How would you describe your present level of personal stress?
Minimal_____ Average_____ Considerable_____ Unbearable_____

What is the main stressor?
Financial_____ Job Related_____ Interpersonal_____ Marriage_____
Health_____ Expectations_____ Family Members_____ Spiritual_____

Food Supplements

List all the food supplements you are currently taking. Indicate the total dosage taken in one day (i.e. if you take two tablets of Vitamin C 500mg/day, then the total daily is 1000mg)

_____
_____
_____
_____
_____
_____
_____

Prescription Drugs

List all prescription drugs that you are currently taking. Indicate present dose and how long you have been on each medication.

_____
_____
_____
_____
_____
_____
_____

List all prescription drugs you have taken in the past for longer than six months. Indicate how long you were on each medication.

_____
_____
_____
_____
_____
_____
_____

How many times have you been prescribed antibiotics over the last 10 years?_____

Were you ever on antibiotics for an extended period of time? Please explain when and for how long: _____

Have you used probiotics ("friendly" microflora) following antibiotic use?
Always_____ Often _____ Occasionally _____ Never _____

MEN'S HEALTH:

Do you ever have difficulties getting and maintaining erections?
(never, occasionally, often, always) Explain: _____
_____
_____

Do you have difficulties with premature ejaculation while having intercourse?
(never, occasionally, often, always) Explain: _____
_____
_____

Is your sexual energy: Non-existent ___ Low ___ Medium ___ High ___ Very High ___

Are your erections ever painful? _____
_____

Do you have any difficulty voiding (urinating) completely? _____
_____

How often do you get up to go to the bathroom at night? _____
_____

Have you ever been diagnosed with prostate problems? _____
_____
_____

Have you ever had a sexually transmitted disease? _____
_____

How many children have you fathered? _____ How many have you raised? _____

Do you have any other issues concerning sex? If yes, please describe. _____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Is there anything you would like to add or elaborate on that has not been included in this intake form?_____

Thank you for taking the time to fill out this questionnaire.
It will help greatly in the study of your present health concerns
and in understanding your health goals.
Your responses will assist in choosing the appropriate course of action that will hopefully bring about your return to optimal health.
I look forward to working with you towards this goal.