orléans naturopath
NATUROPATHIC MEDICINE & ACUPUNCTURE

INTAKE FORM

Date: _____

Name: _____ Date of birth: (M/D/Y) _____ Sex: M F

Address: _____

_____

E-mail Address: _____

Telephone number: Home: _____ Cell: _____

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

Emergency contact name: _____

Emergency contact phone number: _____ Relation: _____

How did you hear about the clinic? _____

Other health care providers you are seeing:

1. _____
_____
_____
Phone number ( ) _____

2. _____
_____
_____
Phone number ( ) _____

3. _____
_____
_____
Phone number ( ) _____

4. _____
_____
_____
Phone number ( ) _____

What are your health concerns, in order of importance to you:

1. _____
2. _____
3. _____
4. _____
5. _____

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If you are female are you currently pregnant or do you suspect yourself to be pregnant? Y N

MEDICAL HISTORY

How would you describe your general state of health?
EXCELLENT / GOOD / FAIR / POOR

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

Do you have any allergies (medicines, environmental, etc.)?

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

Please list past prescription medications.

How many times have you been treated with antibiotics?

Do you frequently use any of the following? (circle)
ASPIRIN / LAXATIVES / ANTACIDS / DIET PILLS / BIRTH CONTROL PILLS / IMPLANTS / INJECTIONS

Alcohol—how much/day or week

Tobacco—form and amount/day

Caffeine—form and amount/day

Recreational drugs—what and how often?

Please indicate what immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus influenza B
- ☐ Hepatitis A
- ☐ Tetanus booster; when?
- ☐ "Flu"
- ☐ Hepatitis B
- ☐ MMR (measles, mumps, rubella)
- ☐ Polio
- ☐ Smallpox

Other

Please indicate if any caused adverse reactions:

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y N

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DIET

Do you have any food allergies or intolerances? Please list.

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

Describe a typical day's diet:

Breakfast

Lunch

Dinner

Snacks

Beverages (and total quantity)

FAMILY HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

Please indicate which family member

Allergies

Asthma

Heart Disease

High Blood Pressure

Cancer

Diabetes

Depression

Other Mental Illness

Drug Abuse/Alcoholism

Kidney Disease

Other

☐ I don't know my family medical history

ENVIRONMENT

Occupation

Hobbies

Do you exercise regularly? Y N

What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)? Y N

Are you frequently exposed to animals (work, pets, etc.)? Y N

How is your home heated? _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe. _____

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life?

How well do you handle these stresses? _____

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