

**GENERAL INTAKE FORM
FAMILY HEALTH HISTORY**

	Mother	Father	Brother (s)	Sister (s)	Spouse	Children
Age (if living)	_____	_____	_____	_____	_____	_____
Health (Poor/Fair/Good/Great)	_____	_____	_____	_____	_____	_____
Age at Death (if applicable)	_____	_____	_____	_____	_____	_____
Cause of Death (if applicable)	_____	_____	_____	_____	_____	_____

Has anyone in your family had any of the following conditions (s) ? If yes, please circle and indicate who and age of diagnosis.

- | | |
|--------------------------------|---|
| Asthma / Allergies | Headaches / Migraines |
| Anaemia (low red blood cells) | Infertility |
| Arthritis | Lupus |
| Alcoholism / Drug Addiction | Menière's Disease |
| Alzheimer's Disease | Mental Illness |
| Aneurysm | Multiple Sclerosis |
| Anxiety | Nervous Disorder |
| Bruising or Easy Bleeding | Panic Attacks |
| Blood Pressure (high / low) | Parkinsons Disease |
| Cardiovascular Disease (heart) | Respiratory Disease (lung) |
| Cancer (type) | Scleroderma |
| Crohn's Disease | Stroke |
| Depression | Suicide |
| Diabetes (type I / type II) | Tuberculosis |
| Eczema | Thyroid disease ☒(hypothyroidism / hyperthyroidism) |
| Epilepsy | Ulcer |
| Glaucoma | Vertigo |

Other _____

Please add any pertinent information regarding family health history that you may feel is important.

**GENERAL INTAKE FORM
PERSONAL HEALTH HISTORY**

Major Health Concerns

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

List in order of importance the health concern(s) you would like treated

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

PRESCRIPTION Medications

Are you currently taking prescription medications on a regular basis, including birth control, allergy medications, etc?

	Medication Name / Brand	Daily Dosage # of Times / day	Reason	Length of Time	Side Effects (if any)
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Other information

NON-PRESCRIPTION Medications / Supplements

Are you currently taking non-prescription medications, including vitamins, minerals, herbs, etc?

	Medication / Supplements Name / Brand	Daily Dosage # of Times / day	Reason	Length of Time	Side Effects (if any)
1.	_____	_____	_____	_____	_____
2.	_____	_____	_____	_____	_____
3.	_____	_____	_____	_____	_____
4.	_____	_____	_____	_____	_____
5.	_____	_____	_____	_____	_____

Other information

GENERAL INTAKE FORM PERSONAL HEALTH HISTORY

Have you had any of the following CHILDHOOD ILLNESSES? (Please circle most appropriate answer)

Scarlet fever	German Measles	Polio	
Mumps	Rheumatic fever	Other	_____
Measles	Diphtheria		_____

Have you had the following IMMUNIZATIONS?

Rubella	Pertussis	Polio	
Mumps	Tetanus	Other	_____
Measles	Diphtheria		_____

Have you had all standard vaccinations? Yes No

Have you had any side effects or allergic reactions to vaccinations? Yes No

If yes, please specify (including name of vaccination, symptoms, age, year) _____

GENERAL HEALTH INFORMATION

Are you following a special diet? Yes No

If yes, please specify _____

Are you currently receiving any other treatment, including massage therapy, chiropractic, etc? Yes No

If yes, please specify _____

Have you had previous naturopathic medical care? Yes No

If yes, please specify (include when and with whom) _____

Do you have any allergies / sensitivities, including environmental, substance, food, etc? Yes No

If yes, please specify (include symptoms) _____

Have you experienced major injuries / accidents / falls? Yes No

If yes, please specify (include age, impact on health) _____

**GENERAL INTAKE FORM
PERSONAL HEALTH HISTORY**

GENERAL HEALTH INFORMATION (Please circle most appropriate answer)

Have you had any surgeries? Yes No
 If yes, please specify (include type, reason, age, impact on health, etc) _____

Have you had any hospitalizations / illnesses? Yes No
 If yes, please specify (include age, length, impact on health, etc) _____

Have you had any X-rays, Cat Scans, MRI's or other special procedures? Yes No
 If yes, please specify (include type, when, etc) _____

DENTAL

Do you have any major problems with your teeth / gums? Yes No
 Do you have many fillings in your teeth? Yes No
 If yes, are they mercury fillings? Yes No

Additional Information _____

TRAVEL ILLNESS

Have you ever experienced an illness when travelling? Yes No
 If yes, please specify (include type of illness, symptoms, location, age, year, treatment, etc) _____

SMOKING HISTORY

Do you currently smoke tobacco? Yes No If yes, how many per day? _____
 What age did you start smoking? _____
 Does smoking affect your health in a negative or positive way? _____

Do you depend on the use of other substances on a regular basis, including caffeine, alcohol, cannabis, etc?
 If yes, please specify _____

GENERAL INTAKE FORM PERSONAL HEALTH HISTORY

PHYSICAL HISTORY (Please circle most appropriate answer)

Date of last physical exam _____

DD / MM / YY

Significant findings (i.e.. High blood pressure, heart murmur, low/high iron, cholesterol, thyroid, etc)

Current Weight _____	Weight 1 year ago _____	Most ever weighed _____
"Ideal weight" _____	Height _____	

Current history of STD? Yes No

If yes, please specify? _____

MALE

Date of last DRE (prostate exam) _____

DD / MM / YY

Have you had a PSA test? Yes No

Significant Findings _____

FEMALE

Date of last PAP test _____

DD / MM / YY

Have you had a mammogram? Yes No

Do you practice self-breast exams? Yes No

If yes, how often? _____

GESTATIONAL HISTORY

Number of pregnancies _____	Number of pregnancies to term _____	
Number of children _____	Ages / gender _____	

Did you have difficulty with conception? Yes No

If yes, please specify _____

**GENERAL INTAKE FORM
PERSONAL HEALTH HISTORY**

GESTATIONAL HISTORY (Please circle most appropriate answer)

How was your health during the pregnancy? _____

Was it a vaginal birth delivery? Yes No
 Were there any complications? _____

Was it a C-section delivery? Yes No
 If yes, what was the reason for the C-section? _____
 Were there any complications? _____

Was there any health concerns with you during or after the birth? _____

Was there any health concerns with the baby during or after the birth? _____

Did you breast feed? Yes No If yes, how long? _____
 Any complications? _____

Have you experienced post-partum depression? Yes No If yes, how long? _____
 How was it treated? _____

What did you experience during this time? _____

Have you had any miscarriages? Yes No If yes, how many? _____
 At what point in the pregnancy? _____

Have you had any abortions? Yes No If yes, how many? _____
 If yes, did you experience any complications? Yes No
 Please specify _____

*Thank you for completing this intake form .
 The information you have provided us will give us greater insight so that we can better help you!*