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ADULT INTAKE FORM

File Number: _____ Date _____

Last Name: _____ First/Middle Name: _____

Date of Birth: _____ Gender: Female Male
mm/dd/yy

Address: _____
Apt/House Number Street Name

City Province Postal Code

Home Phone: _____ Cell Phone: _____

May we leave phone messages relating to your visits? YES NO

Email: _____

May we send you our seasonal newsletter and monthly calendar of events via email? YES NO
Your email address will not be shared and you may unsubscribe at any time by email or phone.

How did you hear about the Mahalo Naturopathic Centre? (if another person, please provide name)

Occupation/Employer: _____ Work Phone: _____

Emergency Contact: _____
Name Relation Phone Number

Care Co-ordination

Family Doctor: _____ Phone Number: _____

Date of Last Visit to a Medical Doctor: _____ Date of Last Full Physical Exam: _____

Other Practitioners: _____

Have you been treated by a Naturopathic Doctor before? YES NO

If yes, by whom? _____ When? _____

How would you describe your general state of health? (circle one) excellent good fair poor

Health Concerns/History

Please list your concerns in order of importance

| Onset | Concerns/Goals | Present Treatment/Comments |
|-------|----------------|----------------------------|
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| | | |

Allergies and Sensitivities

Please list any known or suspected allergies, sensitivities, and/or intolerances to foods or drugs

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Medications/Supplements

Please list all current medications and supplements including prescription drugs, over the counter drugs, herbs, vitamins, minerals, homeopathics, etc.

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Past Prescriptions

Please list past prescription medications

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Injuries, Surgeries, Hospitalizations

Please list any past serious injuries, surgeries, and hospitalizations

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Immunizations

| | | |
|--------------------------------------|-----------------|--------------|
| MMR (Measles, Mumps, Rubella) | Polio | Hepatitis A |
| DPT (Diphtheria, Pertussis, Tetanus) | Meningitis | Hepatitis B |
| Haemophilus Influenza B (Hib) | Smallpox | Rabies |
| Chicken Pox (Varicella Zoster) | Tetanus booster | Yellow Fever |
| Typhoid | Other: | Other: |

Have you had adverse reactions to any vaccine? YES NO If yes, please explain: _____

Have you taken antibiotics within the past 5 years? YES NO If yes, how many times? _____

Past Medical History

| | | | | | |
|-------------|--|-----------------|--|----------------|--|
| Chicken Pox | | Scarlet Fever | | Tonsillitis | |
| Measles | | Pneumonia | | Ear Infections | |
| Mumps | | Frequent Colds | | Other: | |
| Rubella | | Rheumatic Fever | | | |

Do you use any of the following

| | | | | | |
|--------------------|--|------------|--|---------------------|--|
| Alcohol | | Laxatives | | Tea | |
| Cigarettes | | Antacids | | Birth Control Pills | |
| Recreational Drugs | | Diet Pills | | Hormone Therapy | |
| Aspirin | | Coffee | | Other: | |

Screening Tests

Please indicate which of the following you receive

| Test | Circle One | | | How often |
|----------------------------|------------|----|-------|-----------|
| PAP test (women) | YES | NO | NEVER | |
| Breast exam | YES | NO | NEVER | |
| Mammogram | YES | NO | NEVER | |
| DEXA scan | YES | NO | NEVER | |
| Digital rectal exam (men) | YES | NO | NEVER | |
| PSA test (men) | YES | NO | NEVER | |
| Cholesterol | YES | NO | NEVER | |
| Blood Glucose | YES | NO | NEVER | |
| CBC (complete blood count) | YES | NO | NEVER | |
| Other | YES | NO | NEVER | |
| Other | YES | NO | NEVER | |

Family History

| Condition | Circle One | | Family Member(s) | Complications/Severity |
|------------------------|------------|----|------------------|------------------------|
| Allergies | YES | NO | | |
| Asthma | YES | NO | | |
| Diabetes | YES | NO | | |
| Heart Disease | YES | NO | | |
| Cancer | YES | NO | | |
| Depression | YES | NO | | |
| Other Mental Illness | YES | NO | | |
| Kidney Disease | YES | NO | | |
| Infertility | YES | NO | | |
| High Blood Pressure | YES | NO | | |
| Drug Abuse/ Alcoholism | YES | NO | | |
| Other | YES | NO | | |

General Personal Information

Height _____ Weight _____

Have you lost or gained any weight in the last 6 months? YES NO If yes, how much? _____

Marital Status _____ How long have you been married (if applicable): _____

Number of Children (if applicable): _____ Stress level at home (0 none, 10 extremely stressful): _____

Occupation: _____ Stress level at work (0 none, 10 extremely stressful): _____

Number of Hours worked in a week: _____ Do you like your work? YES NO

What hobbies do you enjoy? _____

Physical Activity

Are you physically active? YES NO

If yes, describe and indicate type and amount per average week: _____

After physical activity, do you generally feel: Energized Happily Fatigued Tired Exhausted

Diet Type (non-vegetarian, vegetarian, vegan...) _____ How long? _____

Describe your typical daily diet

Breakfast: _____ Snacks: _____

Lunch: _____ Beverages: _____

Dinner: _____ Water: _____

Have you noticed any general trends with respect to your health? (for example, get sick easily or not as much as others, difficulty getting a restful sleep, muscles feeling stronger or weaker than normal, more or fewer chest infections than normal, more or less energy than normal) If yes, please explain:

Have you had any minor or major conditions, after which, you feel you have never fully recovered? If yes, please explain:

If there is any other information pertaining to your health that you feel is important but has not covered in this intake please state it on the back of this page.

Thank you!