

Adult Intake Form

Name _____ Date of 1st Visit _____

Date of Birth _____ Age _____ Gender M F

Address _____

City _____ Province _____ Postal Code _____

Phone (home) _____ (work &/or cell) _____

E-mail _____

Occupation _____ Hours Full-Time Part-Time Over-Time

Marital Status Married Separated Divorced Widowed Single Partnership

Number of Children _____ Ages _____ Sexes _____

Emergency Contact

Name _____ Phone _____

Relationship _____ Address _____

Health Care Providers

Name _____ Name _____ Name _____

MD Chiropractor RMT

Osteopath Counsellor

Other _____

MD Chiropractor RMT

Osteopath Counsellor

Other _____

MD Chiropractor RMT

Osteopath Counsellor

Other _____

List your primary health concerns, in order of importance:

1.

2.

3.

How did you hear about Lorraine Caruso, ND? _____

Have you received naturopathic treatment in the past? Yes No

Personal Overview

1. What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? Please list.

2. What behaviours or lifestyle habits do you currently engage in regularly that you believe are self-destructive to your health? Please list.

3. What potential obstacles do you foresee in adhering to therapeutic protocols?

4. What is your support system like? Do you have people who will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

5. What expectations do you have of me as your Naturopathic Doctor?

6. Reversing illness by treating the underlying causes, and effectively managing health *does not happen overnight*. It often requires a commitment to lifestyle change.

How would you describe your present level of commitment to making changes in your health on a scale from 1 to 10?

(0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

Health History

How would you describe your current state of health? Excellent Good Fair Poor

Are you currently being treated for a health care concern by other healthcare practitioners? Please explain.

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have had.

Illnesses

Please indicate if you have ever had any of the following illnesses.

- | | | |
|--|-------------------------------------|--|
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Mumps | <input type="checkbox"/> Measles | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Shingles | <input type="checkbox"/> Tuberculosis |

Medications

List all prescription and over-the-counter medications you take.

Name of medication _____ Daily dose _____
Name of medication _____ Daily dose _____
Name of medication _____ Daily dose _____

Did you receive antibiotics frequently as a child? Y N
How many times have you received antibiotics in the past three years? _____

Supplements

List all vitamins, minerals, herbs or other supplements that you take.

Name of supplement _____ Daily dose _____
Name of supplement _____ Daily dose _____
Name of supplement _____ Daily dose _____
Name of supplement _____ Daily dose _____

Vaccinations

What vaccinations have you had?

- DPT/DaPT Polio (IPV or Oral)
(diphtheria/pertussis/tetanus)
- Haemophilus influenza B (HiB) Flu shot
- MMR (measles, mumps, rubella) Hepatitis A&B
- Chicken pox (Varivax)

Have you experienced any adverse reactions from a vaccination? Y N

If yes, please explain. _____

Allergies

Are you sensitive or allergic to:

Any drugs? _____
Any foods? _____
Any environmental? _____
Any chemicals? _____
Any supplements? _____

Have you ever had an anaphylactic reaction (hives, trouble breathing, etc.)? Y N

Family History

	Father	Mother	Brothers	Sisters	Spouse	Child
Age if living						
Age at death-if deceased						

Check (✓) if applicable

Cancer						
Diabetes						
Heart Disease/ High Blood Pressure						
Alcoholism/drug use						
Depression/Mental Illness						
Asthma						
Allergies/Hay fever						
Kidney Disease						
Autoimmune disease						
Eczema/Psoriasis						

Thyroid issues						
Other						

Lifestyle

Eating

- Do you eat three meals a day? Y N
- Do you eat out often? Y N
- Do you crave/eat sugary foods? Y N How often? _____
- Do you crave/eat salty foods? Y N How often? _____
- Do you drink cola/soft drinks? Y N Diet Reg How often? _____
- Do you drink coffee/black tea? Y N How often? _____

Drugs

- Do you drink alcohol? Y N How often? _____
- Do you smoke cigarettes/cigars/use tobacco? Y N How often? _____
- Have you smoked in the past? Y N For how many years? _____
- Are you regularly exposed to 2nd hand smoke? Y N Past
- Do you use recreational drugs? Y N How often? _____

Work & Play

- Do you enjoy your work? Y N
- Do you take vacations? Y N
- Interests and hobbies _____
- Do you exercise? Y N
- What do you do and how often? _____

- How much time do you spend outdoors? _____
- Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Y N
- Please describe. _____

Mental/Emotional

- How would you describe the emotional climate of your home? _____
- How stressful is your life and how well do you handle these stressors? _____

Sleep & Energy

- Do you sleep soundly? Y N
- Do you fall asleep easily? Y N
- Do you wake refreshed? Y N
- Do you wake during the night? Y N Do you fall back to sleep easily? Y N
- Do you have a regular sleep routine? Y N Bedtime _____ Wake-up time _____
- What time of day is your energy best? _____
- What time of day is your energy worst? _____

General

- Weight? _____ Weight a year ago? _____
- Maximum weight? _____ When? _____
- Any unexplained weight loss or weight gain? Y N If so, please explain. _____

Review of Systems

Please indicate whether you experience any of the following. Please circle P if you have experienced any of the following in the **past**.

SKIN

Eczema, hives?	Y N P	Lumps?	Y N P
Acne, boils?	Y N P	Hair loss?	Y N P
Itching?	Y N P	Dryness?	Y N P
Colour change?	Y N P	Night sweats?	Y N P
Temperature change?	Y N P	Change in a mole?	Y N P

HEAD & NECK

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P
Goiter	Y N P	Swollen glands?	Y N P

EYES

Glasses/contacts?	Y N P	Double vision?	Y N P
Eye pain?	Y N P	Spots in vision?	Y N P
Tearing or dryness?	Y N P	Blurred vision?	Y N P
Glaucoma?	Y N P	Colour blindness?	Y N P
Sensitive to the sun?	Y N P	Cataracts?	Y N P
Itching/redness? Discharge?	Y N P	Blind spot?	Y N P

EAR, NOSE & THROAT

Impaired hearing?	Y N P	ringing?	Y N P
Earaches?	Y N P	Vertigo?	Y N P
Discharge?	Y N P	Infections?	Y N P
Sinus problems? Stiffness?	Y N P	Nose bleeds?	Y N P
Frequent sore throat?	Y N P	Hay fever?	Y N P
Teeth grinding?	Y N P	Loss of smell?	Y N P
Gum problems?	Y N P	Loss of taste?	Y N P
Amalgam fillings?	Y N	Sore tongue/mouth?	Y N P
Jaw clicks?	Y N P	Hoarseness?	Y N P

RESPIRATORY

Cough?	Y N P	Pain on breathing?	Y N P
Spitting up blood?	Y N P	Sputum?	Y N P
Asthma?	Y N P	Wheezing?	Y N P
Pneumonia?	Y N P	Bronchitis?	Y N P
Emphysema?	Y N P	Shortness of breath?	Y N P
Tuberculosis?	Y N P	Shortness of breath lying down?	Y N P

CARDIOVASCULAR

High blood pressure?	Y N P	Angina?	Y N P
Low blood pressure?	Y N P	Murmurs?	Y N P
Blood clots?	Y N P	Fainting?	Y N P
Phlebitis?	Y N P	Palpitations/fluttering?	Y N P
Rheumatic fever?	Y N P	Chest pain?	Y N P

Swelling in ankles?	Y N P	Past ECG (Echocardiogram)?	Y N P
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GASTROINTESTINAL

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Heartburn/ Indigestion?	Y N P
Vomiting blood?	Y N P	Constipation?	Y N P
Blood in stool?	Y N P	Diarrhea?	Y N P
Abdominal pain or cramps?	Y N P	Worms/Parasites?	Y N P
Belching or passing gas?	Y N P	Gall Bladder stones?	Y N P
Black, tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease?	Y N P	Hernia?	Y N P
Bowel movements -how often?		Change in bowel movements?	Y N P

URINARY

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency?	Y N P	Inability to hold urine?	Y N P
Urination at night?	Y N P	Kidney stones?	Y N P
Urgency or hesitancy?	Y N P	Blood in urine?	Y N P

MALE REPRODUCTIVE SYSTEM

Hernias?	Y N P	Enlarged prostate or disease?	Y N P
Testicular pain or masses?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia?	Y N P
Impotence?	Y N P	Gonorrhea?	Y N P
Premature ejaculation?	Y N P	Condyloma (i.e. genital warts)?	Y N P
Do you use birth control? What type?	Y N P	Herpes?	Y N P
		Syphilis?	Y N P

FEMALE REPRODUCTIVE SYSTEM

Age at first menses?		Difficulty conceiving?	Y N P
Age at last menses/ Menopause		Cervical dysplasia?	Y N P
Typical duration of bleed?		Pain during intercourse?	Y N P
Typical length of cycle?		Number of pregnancies?	
Are cycles regular?	Y N P	Number of live births?	
PMS?	Y N P	Number of miscarriages?	
Painful menses?	Y N P	Number of abortions?	
Heavy or excessive flow?	Y N P	Menopausal symptoms?	Y N P
Bleeding between periods?	Y N P	Gonorrhea?	Y N P
Clotting during menses?	Y N P	Herpes?	Y N P
Unusual vaginal discharge?	Y N P	Chlamydia?	Y N P
Vaginal itching?	Y N P	Condyloma? (i.e. genital warts)	Y N P
Date of last PAP?		Syphilis?	Y N P
Abnormal PAP?	Y N P	Do you do breast self-exams?	Y N P
Endometriosis?	Y N P	Breast pain or tenderness?	Y N P
Ovarian cysts?	Y N P	Breast lumps?	Y N P
Have you had a mammogram?	Y N P	Nipple discharge?	Y N P
Are you sexually active?	Y N P		
Do you use birth control?	Y N P		

MUSKULOSKELETAL

Joint pain or stiffness?	Y N P	Weakness?	Y N P
Broken bones?	Y N P	Sciatica?	Y N P
Muscle spasms or cramps?	Y N P	Backache?	Y N P
Joint swelling?	Y N P	Neck pain/stiffness?	Y N P

BLOOD & PERIPHERAL VASCULAR

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet/other?	Y N P
Varicose veins?	Y N P	Extremity swelling?	Y N P
Extremity numbness?	Y N P	Extremity ulcers?	Y N P

NEUROLOGICAL

Seizures/convulsions?	Y N P	Numbness or tingling?	Y N P
Muscle weakness?	Y N P	Speech problems?	Y N P
Vertigo?	Y N P	Loss of balance?	Y N P
Paralysis?	Y N P	Involuntary movement?	Y N P

ENDOCRINE/HORMONAL

Fatigue?	Y N P	Heat or cold intolerance?	Y N P
Excessive thirst?	Y N P	Low blood sugar?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P
Excessive urination?	Y N P	Hormone Therapy?	Y N P

IMMUNE

Chronically swollen glands?	Y N P	Chronic infections?	Y N P
Frequent cold/flu	Y N P	Slow wound healing?	Y N P

MENTAL & EMOTIONAL

Treated for emotional issues?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Seasonal depression?	Y N P

Is there anything else that you would like to add or comment on?

***Thank-you for your time and effort.
I look forward to working with you on your journey to health and well-being.***