LORRAINE CARUSO, ND
DOCTOR OF NATUROPATHIC MEDICINE

THE REGENT HEALTH CENTRE
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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.

□ Scarlet fever	□ Diphtheria	□ Rheumatic fever
□ Mumps	□ Measles	□ Mononucleosis
□ Chicken pox	□ Shingles	□ 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 (diphtheria/pertussis/tetanus)
□ Polio (IPV or Oral)
□ 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 environmentals? _____
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? Stuffiness?	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

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? Syphilis?	Y N P 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? Do you use birth control?	Y N P 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.