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INTAKE FORM – MALE (16 years of age or older)

PLEASE NOTE: WE ARE A FRAGRANCE FREE BUILDING

(Please **circle answer where ever there is a multiple question.)* DATE:_____

NAME: _____AGE: _____DATE OF BIRTH: _____

ADDRESS: _____CITY _____

POSTAL CODE:_____ EMAIL ADDRESS:_____

HOME PHONE: ( )_____WORK PHONE: ( )_____

MARITAL STATUS: S M D W Sep NUMBER OF CHILDREN:_____ REFERRED BY:_____

OCCUPATION: _____EMPLOYER: _____

EMPLOYMENT STATUS: Full-Time Part-Time School Retired Unemployed Self-Employed Other

LIVING SITUATION: Alone Spouse Partner Friend(s) Parent(s)

NAME & AGES OF THOSE LIVING WITH YOU: _____

_____

PETS: _____

NAME OF Partner/Spouse/Parent: _____ OCCUPATION: _____

IN CASE OF EMERGENCY NOTIFY: _____ PHONE NO: _____

RELIGIOUS/SPIRITUAL PREFERENCES: _____

EDUCATIONAL BACKGROUND: _____

HOW DID YOU HEAR ABOUT THE CLINIC? _____

Please **list** the **major complaints in order of importance for you:**

	Complaint	Since	Cause
1.			
2.			
3.			
4.			

MEDICAL STATUS

General Health: Excellent Good Fair Poor

What **medications** are you currently taking?

_____ _____
_____ _____
_____ _____

What was the date of your last full medical examination? The date(s) of any blood test(s) you have had done:

List any **vitamins, supplements, homeopathic** or **herbal medications** you are taking:

_____ _____
_____ _____
_____ _____
_____ _____
_____ _____

What other treatments are you currently following?

_____
_____
_____

Have you ever had your cholesterol level checked? _____ Date(s) _____ Result(s) _____

Health History (Please **circle** if you **Had or Have** any of the following):

Abscesses	Chicken pox	Fungal infections	Kidney disease	Rubella	Tuberculosis	
Alcoholism	Chronic fatigue	Gallstones	Leukemia	Scarlet fever	Typhoid fever	
Allergies	Circulatory problems		Glaucoma	Liver disease	Senility	Venereal warts
Amnesia	Cold sores	Goiter	Migraines	Serious injury	Warts	
Anemia	Colitis	Gonorrhea	Mononucleosis	Sexual abuse	Whooping cough	
Anorexia	Colon disease	Gout	Mumps	Sinusitis	Yellow fever	
Arthritis	Compulsive eating	Hay fever	Parasites/worms	Skin disease		
Asthma	Depression	Heart disease	Peritonitis	Strept throat		
Autoimmune	Diabetes	Hepatitis	Pelvic inflammation	Stroke		
Bleeding disorders	Eczema	Herpes genitalia	Pleurisy	Sunstroke		
Cancer	Emphysema	Hypertension	Pneumonia	Syphilis		
Candida (Yeast)	Epilepsy	Hypoglycemia	Rheumatic fever	Tonsillitis		

Other Past Medical Conditions

High Blood Pressure		Stroke	Varicose Veins	Phlebitis	Clotting defects	Bleeding tendencies
Blood transfusion	Diabetes	Kidney trouble	Rheumatic fever	Jaundice/Hepatitis	Epilepsy	
Arthritis	Colitis	Asthma	Chronic Fatigue Syndrome/Eptein Barr			

Childhood diseases: German Measles Chicken Pox Other: _____

Heart Trouble: _____Fractures: _____Cancer _____Eating Disorder_____

Other major conditions?_____

Never well since an illness or infection (What?)_____

Had a chronic/reoccurring infection or problem (What?)_____

HABITS

Dietary preferences/restrictions: _____

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Routine physical exercise?

Type of exercise: _____

For how many minuets? _____ How often? _____

Tobacco use (how much): _____ Previously? _____ How much? _____ How long?_____

Alcohol use (how much): _____ How often? _____

Caffeine use (how much): _____ Mood altering substance use (e.g. marijuana, cocaine) past & present? _____

_____

STRESSES

Stresses (family, work, self, etc.): _____

_____

_____

Have you had any **Hospitalization, Surgeries,** etc. List what type they were, when they occurred and if there were any complications.

Diagnosis/Operation	Hospitalization/Date	Doctor	Complications

CURRENT/RECENT HEALTH CARE PROVIDER(S)

Name	Date(s)	Care Provided

Which of the following **ailments**, or any **other major ailments**, have affected your **relatives**? Please **circle:**

Alcoholism	Asthma	Diabetes	Gout	Insanity	Skin disease
Allergies	Cancer	Epilepsy	Hay fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart disease	Pneumonia	Tuberculosis

Other:_____

Relatives	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

REVIEW OF SYSTEMS

Circle any symptoms of **present** significance.

GENERAL PHYSICAL

Fever or Chills | Unusual Hair Growth | Skin Eruptions | Weight Change

ABDOMOMEN

Bloating | Heartburn/Indigestion | Cramps or pain | Nausea or Vomiting
Diarrhea | Constipation | Change in bowel habits | Bloody or tarry stools
Hemorrhoids | Flatulence

HEAD

Headaches | Dizziness | Visual defects | Hearing defects
Sinus trouble | Fainting spells

BLADDER

Frequent urination | Painful urination | Blood in urine
Inability to hold urine | Inability to empty bladder | Need to get up in the night to urinate

CHEST

Chest pain | Shortness of breath | Heart murmur | Mitral valve prolapse
Palpitations | Chronic cough | Coughing up blood | Wheezing

COMMENTS OR OTHER CONCERNS:

_____

_____

DENTAL HISTORY

Name of Dentist _____ Address: _____

Phone Number _____

Date of last dental check-up _____ for what? _____

Do you have: Root Canals _____ how many? _____

Cavities _____how many? _____

Gum Disease _____

What are your goals and/or expectations of visiting a Naturopathic Doctor?

_____

_____

What changes have been made to improve your quality of life?

_____

_____

**** Please be advised that a cancellation fee of $40 applies to appointments missed without 24 hours notice. (Weather permissible.)***