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**INTAKE FORM - FEMALE**

**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) \_\_\_\_\_  
 Have you ever had a mammogram? \_\_\_\_\_ Date(s) \_\_\_\_\_ Result(s) \_\_\_\_\_  
 Do you do self-breast exams? \_\_\_\_\_

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

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

**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 minutes? \_\_\_\_\_ 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

**PREGNANCIES (including miscarriages and abortions)**

Dates	How Far Along?	Sex	Weight	Problems?

**GYNECOLOGICAL HISTORY**

Date last period began: \_\_\_\_\_ Date of last pelvic exam: \_\_\_\_\_  
 Date prior period began? \_\_\_\_\_ Date of last Pap smear: \_\_\_\_\_  
 Was your last Pap smear normal? \_\_\_\_\_ Age at first period: \_\_\_\_\_  
 Did you ever have an abnormal Pap? \_\_\_\_\_ When: \_\_\_\_\_ Results: \_\_\_\_\_  
 Treatment: \_\_\_\_\_  
 Are you sexually active? \_\_\_\_\_ Do you have intercourse? \_\_\_\_\_ Do you practice safe sex? \_\_\_\_\_  
 Are you trying to get pregnant? \_\_\_\_\_ How long? \_\_\_\_\_  
 Current birth control method: \_\_\_\_\_ How long? \_\_\_\_\_  
 Problems with current birth control method? \_\_\_\_\_  
 Past birth control methods: \_\_\_\_\_  
 Normally (not on pills), the number of days from the start of one period to the start of the next? \_\_\_\_\_  
 Number days of flow: \_\_\_\_\_ Amount of bleeding: \_\_\_\_\_ Amount of cramps: \_\_\_\_\_  
 Premenstrual symptoms: \_\_\_\_\_ Starting when? \_\_\_\_\_  
 Any current changes in your normal pattern? \_\_\_\_\_  
 Any bleeding between periods? \_\_\_\_\_ When? \_\_\_\_\_  
 Any unusual pelvic pain, pressure, or fullness? \_\_\_\_\_ When? \_\_\_\_\_  
 Describe: \_\_\_\_\_  
 Any unusual vaginal discharge or itching? \_\_\_\_\_ Describe: \_\_\_\_\_  
 How long? \_\_\_\_\_ Past treatment: \_\_\_\_\_  
 Any sexual concerns to discuss? \_\_\_\_\_  
 Any past history of tubal infection? \_\_\_\_\_ When? \_\_\_\_\_  
 Any past history of sexually transmitted disease? \_\_\_\_\_ What & When: \_\_\_\_\_  
 Any history of DES exposure (DES was a drug taken by mothers during pregnancy to prevent miscarriage)? \_\_\_\_\_  
 Other: \_\_\_\_\_

**CURRENT/RECENT HEALTH CARE PROVIDER(S)**

Name	Date(s)	Care Provided

**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 \_\_\_\_\_

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 | Hot Flashes | 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              |

**BREASTS**

- |       |          |           |            |
|-------|----------|-----------|------------|
| Lumps | Bleeding | Discharge | Tenderness |
|-------|----------|-----------|------------|

**COMMENTS OR OTHER CONCERNS:**

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

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

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