Dr. Stephen Maltais MSc ND
88 Dover Mills Road
Port Dover, ON. N0A 1N1
Phone: (519) 583-1234
e-mail: docmaltais@kwic.com
www.dovernaturopath.com

INTAKE FORM – FEMALE

NOTE: We try to be a fragrance free clinic.

(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.			
1.			
1.			
1.			

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 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**

_____

_____

_____

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? _____

Does your child have: Root Canals _____ how many? _____

Cavities _____how many? _____

Gum Disease _____

Age of child for first tooth _____ Age of child for permanent teeth _____

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:
_____
_____

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 $90 applies to appointments missed without 24 hours notice. (Weather permissible.)***