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INTAKE FORM – MALE

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) _____

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 Serious injury 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 Stroke
Cancer Emphysema Hypertension Pleurisy Sunstroke
Candida (Yeast) Epilepsy Hypoglycemia Pneumonia Prostate issues Erectile issues

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, pills) 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**

_____
_____
_____
_____

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 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

Prostate

Nighttime urination= how many times= ?

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.)***