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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.			
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? _____

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 | Gonorrhoea | 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			

ABDOMEN

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
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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.)***