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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.			
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	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.)***