# Adult Intake Form

Name: ______________________________ Date: ____________________

Date of birth: ______________________(M/D/Y) Gender: M F Other

Address: ______________________________

______________________________

______________________________

Email: ______________________________

Phone number(s): ______________________ ______________________

Emergency contact: Name: ______________________ Phone: ________________

How did you hear about the clinic? ____________________________________________

Other health care providers (family doctor, specialist, etc…):

1.____________________ 2.______________________ 3.____________________

____________________ ______________________ ____________________

____________________ ______________________ ____________________

____________________ ______________________ ____________________

( ) ________________ ( ) ________________ ( ) ________________

Please list any known allergies or drug sensitivities:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________



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What are your main health concerns, in order of importance to you?

| Concern | When did it start? | What treatments have you tried? |
| --- | --- | --- |
| 1. ____________________ | __________ | __________ |
| 2. ____________________ | __________ | __________ |
| 3. ____________________ | __________ | __________ |
| 4. ____________________ | __________ | __________ |
| 5. ____________________ | __________ | __________ |

If you are female, are you currently pregnant? Yes No (circle one)

Medical History

Please list all major illnesses, injures and hospitalizations with approximate dates:

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please list all current medications (prescription and over the counter), including dose and frequency of use (i.e. daily, 1x/week):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

Please list all current supplements and natural health products (including dose and frequency):

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________

______________________________________________________________________



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Please list past prescription medications:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

How many times have you been treated with antibiotic?

In the last five years ____________________ Lifetime ___________________

Do you frequently use any of the following? (Check all that apply)

❒ Pain medication (Tylenol/Advil)
How often: ___________________
❒ Antacid/Heart burn medication
Type ______________ How often ___________
❒ Oral birth control pill ❒ Birth control implant ❒ Low dose Aspirin ❒ Laxative

❒ Coffee ______/day ❒ Black tea ______/day ❒ Alcohol ______/week

❒ Cigarettes _____/day ❒ Recreational drugs ____/week Type:

Please indicate which immunizations you have had:

❒ DPT (diphtheria, pertussis, tetanus
❒ Polio
❒ MMR (measles, mumps, rubella)
❒ Flu shot How often _______________________
❒ Tetanus
❒ Haemophilus Influenza B
❒ Chickenpox
❒ Hepatitis A
❒ Hepatitis B
❒ HPV
❒ Other: ___________________

Have you ever experienced an adverse reaction from a drug, vaccine or natural health product? If yes, please describe:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

Do you get regular screening tests done by another doctor? (Blood work, Pap test, prostate exam)? Y / N

When was your last physical? _____________________ Most recent blood work?: _________________

Do you have any food allergies or intolerances? (If yes, please list):

________________________________________________________________________

________________________________________________________________________

Do you have any dietary restrictions? (Vegetarian/vegan, kosher, halal, paleo, ketogenic, etc…)

________________________________________________________________________



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Family History

Please indicate if a close family member (grandparent, parent, sibling, child) has had any of the following.

| Condition | Family member | Condition | Family member |
|---|---|---|---|
| Allergies | | Lung disease | |
| Asthma | | Kidney disease | |
| Heart Attack/Stroke | | Depression | |
| High blood pressure | | Anxiety | |
| Cancer | | Other mental illness | |
| Diabetes | | Addiction | |
| Arthritis | | Bowel disease | |
| Thyroid condition | | Dementia/ Alzheimer's | |
| Osteoporosis | | Autoimmune disease | |
| Other: | | | |

❒ I don't know my family history.

Environmental

Occupation: ________________________________________ Do you enjoy your work? _____________

Hobbies: ____________________________________________________________________________

Do you exercise regularly? What type/how often?

_____________________________________________________________________________________

_____________________________________________________________________________________

Are you exposed to significant toxins at home or work? (i.e., cigarette smoke, solvents, harsh cleaning supplies, lead, etc…) __________________________________________________________________

_____________________________________________________________________________________

_____________________________________________________________________________________



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Who do you live with? How would you describe the emotional climate of your home?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

How stressful is your work, relationships, financial situation, or other aspects of your life? How do you handle stress?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Please rate your energy on a scale of 1 to 10 (with 10 being the best energy you can imagine). /10

Is there a time of day that you feel better or worse?

______________________________________________________________________________

______________________________________________________________________________

How would you describe your present level of commitment to making changes to your health?

0% 25% 50% 75% 100%

What goals/expectations do you have of our work together?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

Is there anything that you feel is important that has not been covered?

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________



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TARA ANCHEL, ND
NATUROPATHIC DOCTOR

**Review of Systems**

**Name** ______________________________ **Date** ________________________

Y A condition you have NOW
P A condition that has been significant in the PAST

| | | | Comments | | | | |
|---|---|---|---|---|---|---|---|
| **1. GENERAL** | | | | | | | |
| Weight | | | | | | | |
| Is this a change? | | | | | | | |
| Maximum weight: | | | When? | | | | |
| Height | | | | | | | |
| Physical fatigue | Y | P | | Mental fatigue | Y | P | |
| Fever | Y | P | | Chills | Y | P | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **2. SKIN** | | | | | | | |
| Rashes | Y | P | | Eczema | Y | P | |
| Acne | Y | P | | Itching | Y | P | |
| Colour changes | Y | P | | Lumps/lipomas | Y | P | |
| Dry Skin | Y | P | | Oily skin | Y | P | |
| Night sweats | Y | P | | Nail changes | Y | P | |
| Change in a mole | Y | P | | Skin cancer | Y | P | |
| Pale/blue lips | Y | P | | Pale/blue nails | Y | P | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **3. HEAD** | | | | | | | |
| Headache | Y | P | | Dizziness | Y | P | |
| Head injury | Y | P | | Concussion | Y | P | |
| Jaw pain/TMJ | Y | P | | | | | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **4. EYES** | | | | | | | |
| Impaired vision | Y | P | | Glasses/contacts | Y | P | |
| Laser eye surgery | Y | P | | Eye pain | Y | P | |
| Dry eyes | Y | P | | Tearing | Y | P | |
| Double vision | Y | P | | Blurred vision | Y | P | |
| Glaucoma | Y | P | | Cataracts | Y | P | |
| Eyelid twitch | Y | P | | Itching | Y | P | |
| Redness | Y | P | | Discharge | Y | P | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **5. EARS** | | | | | | | |
| Impaired hearing | Y | P | | Ringing in ears | Y | P | |
| Earache | Y | P | | Dizziness | Y | P | |
| Discharge | Y | P | | Infections | Y | P | |

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| **6. NOSE/SINUSES** | | | | | | | |
| Frequent colds | Y | P | | Sinus infections | Y | P | |
| Nose bleeds | Y | P | | Stuffiness | Y | P | |
| Allergies | Y | P | | | | | |



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| 7. MOUTH | | | | | | | |
|---|---|---|---|---|---|---|---|
| Sore throat | Y | P | | Sore tongue | Y | P | |
| Mouth/gum ulcers | Y | P | | Cold sores | Y | P | |
| Gingivitis | Y | P | | Receding gums | Y | P | |
| Swollen glands | Y | P | | Hoarseness | Y | P | |
| Cavities/fillings | Y | P | | Loss of taste | Y | P | |

| 8. NECK | | | | | | | |
|---|---|---|---|---|---|---|---|
| Swollen lymph node | Y | P | | Goiter | Y | P | |
| Pain/stiffness | Y | P | | | | | |

| 9. RESPIRATORY | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chronic cough | Y | P | | Asthma | Y | P | |
| Wheezing | Y | P | | Pneumonia | Y | P | |
| Bronchitis | Y | P | | Emphysema | Y | P | |
| Difficulty breathing | Y | P | | Pain on breathing | Y | P | |
| Short of breath | Y | P | | Worse at night | Y | P | |
| Chest X-Ray | Y | P | | When? | | | |

| 10. CARDIOVASCULAR | | | | | | | |
|---|---|---|---|---|---|---|---|
| Heart disease | Y | P | | Angina | Y | P | |
| High blood pressure | Y | P | | Murmur | Y | P | |
| Chest pain | Y | P | | Swollen ankles | Y | P | |
| Palpitations | Y | P | | Past ECG? | Y | P | When? |

| 11. BREASTS | | | | | | | |
|---|---|---|---|---|---|---|---|
| Self exams | Y | P | | Lumps | Y | P | |
| Pain/tenderness | Y | P | | Nipple discharge | Y | P | |

| 12. GASTROINTESTINAL | | | | | | | |
|---|---|---|---|---|---|---|---|
| Trouble swallowing | Y | P | | Heartburn/reflux | Y | P | |
| Change in thirst | Y | P | | Appetite change | Y | P | |
| Nausea | Y | P | | Vomiting | Y | P | |
| Bowel movements – how often? | | | | Is this a change? | Y | N | |
| Blood in stool | Y | P | | Mucous in stool | Y | P | |
| Burping | Y | P | | Passing gas | Y | P | |
| Liver disease | Y | P | | Gallbladder stone | Y | P | |
| Ulcer | Y | P | | Indigestion | Y | P | |
| Cramping | Y | P | | Diarrhea | Y | P | |
| Constipation | Y | P | | Rectal bleeding | Y | P | |
| Hemorrhoids | Y | P | | Hernia | Y | P | |
| Known food allergies or sensitivities? | | | | | | | |

| 13. URINARY | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pain on urination | Y | P | | Increased frequency | Y | P | |
| Frequency at night | Y | P | | Inability to hold | Y | P | |
| Frequent infections | Y | P | | Kidney stones | Y | P | |
| Blood in urine | Y | P | | Urgency | Y | P | |
| Hesitancy | Y | P | | | | | |



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| 14. MALE REPRODUCTIVE | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hernia | Y | P | | Testicular mass | Y | P | |
| Testicular pain | Y | P | | Sexually active | Y | P | |
| Erectile dysfunction | Y | P | | Low libido | Y | P | |
| Sexually transmitted infection | | | | Discharge/sores | | | |
| Sexual orientation | Heterosexual | | | Y | | | |
| | Homosexual | | | Y | | | |
| | Bisexual | | | Y | | | |

| 15. FEMALE REPRODUCTIVE | | | | | | | |
|---|---|---|---|---|---|---|---|
| Age menses began? | | | | Regular cycles | Y | P | |
| Avg # days | | | | Cycle length | | | days |
| Bleeding between periods | Y | P | | Spotting before period | Y | P | |
| Painful periods | Y | P | | Excessive flow | Y | P | |
| PMS: mood change | Y | P | | PMS: other | Y | P | |
| Birth control | Y | P | | Type | | | |
| # of pregnancies | | | | # of live births | | | |
| # of miscarriages | | | | # of abortions | | | |
| Difficulty conceiving | Y | P | | Sexually active | Y | P | |
| Pain during sex | Y | P | | Low libido | Y | P | |
| Sexually transmitted infection | Y | P | | Vaginal discharge/itching | | | |
| Sexual orientation | Heterosexual | | | Y | | | |
| | Homosexual | | | Y | | | |
| | Bisexual | | | Y | | | |
| Last menstrual period | | | | Last PAP | | | |

| 16. MUSCULOSKELETAL | | | | | | | |
|---|---|---|---|---|---|---|---|
| Joint pain | Y | P | | Joint stiffness | Y | P | |
| Rheumatoid arthritis | Y | P | | Osteoarthritis | Y | P | |
| Weakness | Y | P | | Joint swelling | Y | P | |
| Muscle spasm | Y | P | | Muscle cramps | Y | P | |
| Back pain | Y | P | | Neck pain | Y | P | |

| 17. PERIPHERAL VASCULAR | | | | | | | |
|---|---|---|---|---|---|---|---|
| Deep leg pain | Y | P | | Varicose veins | Y | P | |
| Cold hands/feet | Y | P | | Leg cramps | Y | P | |
| Extremity numbness | Y | P | | Extremity coldness | Y | P | |
| Extremity swelling | Y | P | | Extremity ulcers | Y | P | |

| 18. NEUROLOGIC | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fainting | Y | P | | Seizures | Y | P | |
| Paralysis | Y | P | | Muscle weakness | Y | P | |
| Numbness/tingling | Y | P | | Loss of memory | Y | P | |
| Involuntary movement | Y | P | | Loss of balance | Y | P | |
| Speech difficulties | Y | P | | | | | |



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| **19. ENDOCRINE** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Generally too cold | Y | P | | Generally too hot | Y | P | |
| Thyroid condition | Y | P | | Diabetes | Y | P | |
| Excessive thirst | Y | P | | Excessive hunger | Y | P | |
| Excessive urination | Y | P | | Excessive sweating | Y | P | |
| Hypoglycemia | Y | P | | HRT | Y | P | |

| **20. CIRCULATORY/LYMPHATIC** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Anemia | Y | P | | Easy bruising | Y | P | |
| Swollen lymph nodes | Y | P | | Past transfusion | Y | P | |
| Blue/white fingers | Y | P | | Blue/white toes | Y | P | |
| Raynaud’s syndrome | Y | P | | | | | |

| **21. ALLERGIES** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Drug allergy | Y | P | | Which? | | | |
| Vaccine reaction | Y | P | | Sensitive to drugs | Y | P | |
| Hives | Y | P | | Seasonal allergies | Y | P | |
| Other allergies | Y | P | | Which? | | | |

| **22. EMOTIONAL** | | | | | | | |
|---|---|---|---|---|---|---|---|
| Depression | Y | P | | Anxiety | Y | P | |
| Medication for depression | Y | P | | Drug name(s) | | | |
| Mood swings | Y | P | | Tension | Y | P | |
| Phobias | Y | P | | Substance abuse | Y | P | |
| Insomnia | Y | P | | Eating disorder | Y | P | |

| **23. DAILY HABITS** | | | | | | | |
|---|---|---|---|---|---|---|---|
| How many meals/day? | | | | Snacks | | | |
| How many hours sleep? | | | | Naps | Y | N | |
| Do you wake rested? | Y | N | | Do you wake easily? | Y | N | |
| Do you stay up late? | Y | N | | Do you wake at night? | Y | N | |
| Do you have difficulty falling asleep? | Y | N | | Do you take vacations? | Y | N | |
| Do you use phone/tablet/computer before bed? | | | | | Y | N | |
| Do you socialize with friends and/or family? | | | | | Y | N | |



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