Magna Health CENTRE

Integrated | Compassionate | Effective Care

Naturopathic Intake Form

Name:_____ Date: _____

Sex: _____ Age: _____ Date of Birth: _____ (yyyy / mm / dd)

Height: _____ Weight: _____ Max Weight: _____ When? _____

Address _____ City _____ Postal Code _____

Telephone (Home) _____ (Work) _____ (Cell) _____

Email _____

Occupation _____ Employer _____

Emergency Contact _____ Telephone _____

How did you find out about us? _____

What are your goals/expectations in coming here?
1._____
2._____
3. _____
How much are you willing to work to accomplish these goals? 0 1 2 3 4 5 6 7 8 9 10
(0=no work, 10= I'll do anything)

Please list your chief health concerns in order of importance:

Complaint	Since	Possible causes

Please list all medications (prescription, over-the-counter) and natural products you are currently taking:

Medication	Dosage	Since	Purpose	Adverse Effects

Please list any allergies or sensitivities you currently or have previously experienced:

Allergy/sensitivity	Since	Reaction	Possible causes

Please list all hospitalizations, surgeries and/or major injuries you have experienced:

Hospitalization/ Injury:	Year	Outcome/Complications

Please tell us about your family health history: (mother, father, siblings, grandparents)

Family member:	Age (or age at death)	Conditions

Vaccinations: Please indicate which vaccinations you have received.

Vaccination	Y/N	Adverse effects?
Measles, Mumps, Rubella (MMR)		
Diphtheria, Pertussis, Tetanus (DPT)		
Haemophilus Influenza B (Hib)		
Chicken Pox (Varicella Zoster)		
Rabies		
Hepatitis A		
Hepatitis B		
Tetanus		
Polio		
Flu		
Other:		

Screening Tests: Please indicate which of the following screening tests you have received (if known)

Test	Y/N	Results
CBC (complete blood count)		
Blood glucose		
Cholesterol		
PSA test (men)		
Digital rectal exam (men)		
Bone Mineral Density		
Mammogram		
Breast exam		
PAP Test (women)		
Other		

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REVIEW OF SYSTEMS

Y = Yes, currently I am experiencing this concern
P = I have experienced this concern in the past
N = I have never experienced this

Skin, Hair and Nails

Rashes- specify	Y	P	N	
Skin condition- specify	Y	P	N	
Dry skin	Y	P	N	
Itching	Y	P	N	
Change in skin colour	Y	P	N	
Sunburn (how often?)	Y	P	N	
Warts	Y	P	N	
Lumps or abscesses	Y	P	N	
Change in mole	Y	P	N	
Skin cancer	Y	P	N	
Excessive perspiration	Y	P	N	
Night sweats	Y	P	N	
Strong body odour	Y	P	N	
Hair loss	Y	P	N	
Brittle nails	Y	P	N	

Musculoskeletal

Joint pain/stiffness	Y	P	N	
Joint swelling	Y	P	N	
Arthritis	Y	P	N	
Muscle spasm/cramps	Y	P	N	
Muscle weakness	Y	P	N	
Bone fractures	Y	P	N	
Osteoporosis	Y	P	N	

Head

Headaches	Y	P	N	
Migraine headaches	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	
Jaw pain or clicking	Y	P	N	
Teeth grinding	Y	P	N	

Gum problems	Y	P	N	
Teeth problems	Y	P	N	

Ears

Impaired hearing	Y	P	N	
Ringing in ears	Y	P	N	
Earaches/ infections	Y	P	N	
Itchy ear canal	Y	P	N	
Discharge from ear	Y	P	N	

Eyes

Far sighted	Y	P	N	
Nearsighted	Y	P	N	
Colour blindness	Y	P	N	
Poor night vision	Y	P	N	
Visual disturbances	Y	P	N	
Cataracts	Y	P	N	
Glaucoma	Y	P	N	
Blind spots/blindness	Y	P	N	
Double vision	Y	P	N	
Blurring	Y	P	N	
Sensitivity to sun	Y	P	N	
Itchy eyes	Y	P	N	
Dry eyes	Y	P	N	
Red eyes	Y	P	N	
Excessive tearing	Y	P	N	

Nose

Post nasal drip	Y	P	N	
Poor sense of smell	Y	P	N	
Loss of smell	Y	P	N	
Runny nose	Y	P	N	
Nose bleeds	Y	P	N	

Throat

Loss of taste	Y	P	N	
Hoarseness of voice	Y	P	N	

Immune

Chronic infections	Y	P	N	
Cold sores	Y	P	N	
Frequent antibiotics	Y	P	N	
Frequent cold/flu	Y	P	N	
Frequent sore throat	Y	P	N	

Shingles	Y	P	N	
Slow wound healing	Y	P	N	
Swollen glands/lymph nodes	Y	P	N	

Respiratory System

Chronic cough	Y	P	N	
Chronic phlegm	Y	P	N	
Coughing up blood	Y	P	N	
Pain while breathing	Y	P	N	
Shortness of breath (when?)	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Chronic lung condition-specify	Y	P	N	

Cardiovascular System

High blood pressure	Y	P	N	
High cholesterol	Y	P	N	
Angina	Y	P	N	
Chest pain	Y	P	N	
Heart murmurs	Y	P	N	
Heart palpitations	Y	P	N	
Heart attack	Y	P	N	
Anemia	Y	P	N	
Fainting	Y	P	N	
Dizziness upon standing	Y	P	N	
Easily bruise/bleed	Y	P	N	
Cold hands and/or feet	Y	P	N	
Numbness in hands/feet	Y	P	N	
Heaviness or pain in legs	Y	P	N	
Leg ulcers	Y	P	N	
Varicose veins	Y	P	N	
Your socks leave imprints on your ankles/ leg swelling	Y	P	N	
Hemorrhoids	Y	P	N	

Gastrointestinal System

Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Burping	Y	P	N	
Bloating	Y	P	N	
Gas	Y	P	N	
Nausea	Y	P	N	
Vomiting (vomiting blood)	Y	P	N	

Stomach cramps or pain	Y	P	N	
Ulcer	Y	P	N	
Constipation	Y	P	N	
Diarrhea or loose stool	Y	P	N	
Undigested food in stool	Y	P	N	
Mucous in stool	Y	P	N	
Black tarry stool	Y	P	N	
Blood in stool	Y	P	N	
Stool floats in toilet bowl	Y	P	N	
Itching around anus	Y	P	N	
Liver disease	Y	P	N	
Gallbladder disease	Y	P	N	

How often do you have a bowel movement? _____
Have you ever travelled to a third world country? _ Yes _ No
If yes, please specify where and for how long: _____
Have you ever had parasites that you are aware of? _Yes _ No

Urinary System

Pain on urination	Y	P	N	
Blood in urine	Y	P	N	
Increased urinary frequency	Y	P	N	
Frequent bladder infections	Y	P	N	
Kidney infections	Y	P	N	
Kidney stones	Y	P	N	
Change in urine colour/odour	Y	P	N	
Must strain to urinate	Y	P	N	
Inability to hold urine	Y	P	N	
Wake at night to urinate	Y	P	N	

Men's Health

Hernia	Y	P	N	
Testicular mass	Y	P	N	
Testicular pain	Y	P	N	
Prostate condition	Y	P	N	
Discharge or sores	Y	P	N	
Low sex drive	Y	P	N	
Sexual difficulties	Y	P	N	
Impotence	Y	P	N	
Sexually active	Y	P	N	

Women's Health

Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Vaginal odour	Y	P	N	
Sores, growths or lumps	Y	P	N	

Abdominal pain mid cycle	Y	P	N	
Abnormal pap tests	Y	P	N	
Menopausal symptoms	Y	P	N	
Low sex drive	Y	P	N	
Sexual difficulties	Y	P	N	
Pain during intercourse	Y	P	N	
Vaginal dryness	Y	P	N	

Breast Health

Fibrocystic breasts	Y	P	N	
Puckering of skin	Y	P	N	
Nipple discharge	Y	P	N	
Tenderness	Y	P	N	
Flaky dry skin on nipple	Y	P	N	
Breast lump	Y	P	N	
Monthly self-breast exams	Y	P	N	
Last breast exam	Y	P	N	
Regular mammograms	Y	P	N	

Menstruation

Pain or cramping	Y	P	N	
Clotting	Y	P	N	
Diarrhea	Y	P	N	
Water retention	Y	P	N	
Bloating	Y	P	N	
Breast tenderness	Y	P	N	
Cravings	Y	P	N	
Mood swings	Y	P	N	
Headache	Y	P	N	
Light flow	Y	P	N	
Heavy flow	Y	P	N	
Bleeding between periods	Y	P	N	
Missed periods	Y	P	N	
Irregular cycles	Y	P	N	
Difficulty conceiving	Y	P	N	

Age of first menses: _____
Age of last menses (if applicable): _____
Average length of cycle (in days): _____
How many days is your menses? ____
Are you sexually active? _ Yes _ No
What type of birth control do you use (if any): _____
Number of pregnancies: _____
Number of miscarriages: _____
Are you currently pregnant? _ Yes _ No If yes, how many weeks: _____

Endocrine:

Diabetes	Y	P	N	
Excessive hunger	Y	P	N	
Excessive sweating	Y	P	N	
Excessive thirst	Y	P	N	
Excessive urination	Y	P	N	
Generally feeling cold	Y	P	N	
Generally feeling hot	Y	P	N	
Hormone therapy	Y	P	N	
Low blood sugar	Y	P	N	
Mental dullness	Y	P	N	
Poor concentration	Y	P	N	
Sluggish after coffee	Y	P	N	
Sluggish after eating	Y	P	N	
Thyroid trouble	Y	P	N	

Rate your energy level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10
Rate your stress level (1=relaxed, 10=stressed) 1 2 3 4 5 6 7 8 9 10
At what time of day is your energy… best _____ worst _____
Have you recently lost or gained weight? _ Yes _ No How much? _____ lost/gained
How many hours of sleep do get per night?_____
Do you wake feeling rested? _____

Mental/Emotional:

Abuse	Y	P	N	
Alcohol/drug abuse	Y	P	N	
Anxiety/nervousness	Y	P	N	
Depression	Y	P	N	
Easily angered	Y	P	N	
Indecision	Y	P	N	
Insomnia	Y	P	N	
Irritability	Y	P	N	
Memory problems	Y	P	N	
Mental illness	Y	P	N	
Mood swings	Y	P	N	
Panic attacks	Y	P	N	
Phobias	Y	P	N	
Prolonged grief/sadness	Y	P	N	

What are three major contributors to stress in your life:
1. _____
2. _____
3. _____

Has there been an illness or event in your life that you feel you have never fully recovered from? If so, please specify?
_____
_____

Lifestyle

Have you ever been a smoker? _ Yes _ No

If yes, how many per day: _____ For how long: _____

Are you exposed to second hand smoke? _ Yes _ No

Do you drink alcohol? _ Yes _ No

If yes, how often: _____ What type:_____

Do you use recreational drugs? _ Yes _ No

How much time do you spend outdoors per week? _____

Do you exercise? _ Yes _ No

If yes, how often: _____

What kind of exercise do you do? _____

Please describe your diet on an average day:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

How much water do you drink per day: _____

What foods do you crave: _____

Do you have any dietary restrictions (e.g religious, vegetarian etc) ? _ Yes _ No

Please specify: _____

Toxic Exposure:

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work or while traveling? _ Yes _ No

_____

Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with pesticides? _ Yes _ No

_____

Are you particularly sensitive to perfume, gasoline or other vapours? _ Yes _ No

Have you ever lived near a refinery or a polluted area? _ Yes _ No

Have you ever lived in a home that is more than 50 years old? _ Yes _ No

Do you have mercury dental fillings? _ Yes _ No

Have you had any dental root canal procedures? _ Yes _ No

Do you have any surgical implants? (cosmetic, medical) _ Yes _ No

Do you live near power lines? _ Yes _ No