ADULT COMPREHENSIVE INTAKE

Emma Stokes, ND
Doctor of Naturopathic Medicine

106-175 Chestermere Station Way Chestermere, Alberta T1X 0A4
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BASIC INFORMATION

First name: _____ Initial: _____ Last name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

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

Email address: _____ Fax: _____

Sex: M ____ F ____ Age: _____ Date of Birth: _____

Occupation: _____

Emergency Contact: _____ _____ _____

(full name) (relation) (telephone)

Name of Medical Doctor: _____ Date of last physical: _____

Phone: ( ) _____ Fax: ( ) _____ Date of last lab tests: _____

Have you been treated by a Naturopathic Doctor? Other health practitioners?

Name(s): _____

When?: _____

Please tell us how you heard of our Clinic? Family ___ Friend ___ Co-Worker ___ Ad ___ Facebook ___

Internet ___ Health Professional ___ Who recommended us to you? _____

Successful health care and preventative medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please take the time to carefully and thoroughly complete this health history questionnaire. Consider copying it for your own future records.

PRIMARY HEALTH CONCERNS

In your opinion, what are your most important health concerns (chief complaints)? Please list in order of importance.

Condition/complaint : Diagnosed By: Since:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____

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How did these conditions develop? Are there traumatic events (surgeries, drug reactions, life trauma) that you can identify as having caused or clearly aggravated your health problems? There is a chronological flow chart on pages 7/8 to assist with listing these conditions, if you prefer.

_____

_____

_____

PRIOR TREATMENTS AND RESPONSE

Please list all of the former treatments you have used, both conventional and alternative and the degree of effectiveness/benefit of each treatment. This greatly aids us in developing an optimal treatment plan for you.

_____

_____

_____

_____

_____

CURRENT MEDICATIONS

Please list all CURRENT prescribed medications:

Drug name:	Purpose:	Dosage:	Length taken:

List all CURRENT non-prescription medication used: _____

_____

List all CURRENT vitamins, minerals, herbs, that you take more than occasionally: _____

_____

List any prescribed medication you've had an adverse reaction to in the past. Indicate the drug name, when you took it and the reaction you had:

Drug name:	When taken:	Reaction:

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Please list any **allergies** you have and what kind of **reaction** occurs.

What prior types of allergy testing have you had?

- Intradermal
- Scratch
- Blood IgG Food
- Blood IgE Inhalant/Food
- Cytotoxic
- Electroacupuncture (VEGA, MORA)
- Kinesiology
- Food intolerance testing
- None

How many times have you been treated with antibiotics in the past 5 years? _____

CHRONOLOGICAL HEALTH HISTORY

Please list all surgeries, accidents or traumatic events you have experienced:

This sort of health history helps to establish trends in a person's health that may be relevant to present conditions. Indicate below any accidents, broken bones, falls, illnesses, hospitalization, surgeries, and any emotional traumas such as deaths, loss of jobs, divorces, or impactful changes in your life etc.

Year 1-5 _____
Year 6-10 _____
Year 10-15 _____
Year 16-20 _____
Year 21-25 _____
Year 26-30 _____
Year 31-35 _____
Year 36-40 _____
Year 41-45 _____
Year 46-50 _____
Year 51-55 _____
Year 55-60 _____
Year 61-65 _____
Year 66-70 _____
Year 71-75 _____
Year 76-80 _____
Year 81-90 _____

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MEDICAL HISTORY

Please circle all illnesses that you have experienced throughout your lifetime. **Write (N) beside the symptoms you are experiencing NOW:**

Measles (Rubeola) German measles (Rubella) Chicken pox Mononucleosis Mumps Whooping cough Scarlet fever Rheumatic fever Polio Reyes syndrome Typhoid Cholera Malaria Food poisoning Worms/parasites Diarrhea Dysentary	Colitis Irritable bowel syndrome Crohn's disease Diverticulitis Hiatal hernia Constipation Hemorrhoids Stomach/duodenal ulcers Appendicitis Eye Problems	Spleen Disease Gallbladder disease Jaundice Pancreatic disease Hepatitis Other liver diseases Prostate problems Kidney problems Bladder problems Hypoglycemia Diabetes	Gonorrhea Chlamydia Syphilis HIV Genital herpes Human papillomavirus HPV Genital Warts PMS Fibrocystic Breasts Uterine fibroids Endometriosis Ovarian cysts Vaginitis (recurrent) Painful periods Infertility Urinary tract infections
Acne Carbuncles, Boils Scabies Poison Ivy Keloids Impetigo Ring worm Eczema Psoriasis Warts Ulcers on any body part Skin cancer Uriticaria Herpes Shingles	Migraine headaches Dizziness/vertigo Numbness Cramps Epilepsy Meningitis Strep throat Scarlet fever Tonsilitis Sinusitis Allergies (environmental) Pneumonia Asthma Pleurisy Bronchitis Tuberculosis Hay fever Receurrent Ear infections	Heart problems Palpitations Circulatory problems High blood pressure Low blood pressure Fainting Anemia Varicose vein Stroke Platelet disorders Sickle cell	Osteoarthritis Rheumatism Back pain/sciatica Fibomylagia Gout Rheumatoid arthritis Malnutrition Rickets Hemochromatosis Osteoperosis Wilson's disease Cushing's disease Addison's disease Hypothyroid Hyperthyroid (thyroiditis)
Cancer (specify)	Myasthenia Gravis Lupus Multiple sclerosis Raynaud's disease Scleroderma	Chronic fatigue syndrome Environmental illness Candida (yeast syndrome)	Anxiety disorder Schizophrenia Bipolar disorder Clinical depression Eating disorder

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Have you been **vaccinated**? N ___Y ___ Did you have any adverse reactions? _____

What vaccines have you had recently? _____

FAMILY MEDICAL HISTORY

Please check all of the following **conditions** that are applicable to **you & your family** and note who next to the condition.

Alcoholism		Heart Murmurs		Diabetes	
Allergies		High Blood Pressure		Eczema	
Arthritis		Hypo/Hyper thyroid		Gallbladder	
Asthma		Irritable Bowel		Gerd/hiatal hernia	
Autoimmune diseases		Kidney disease		Glaucoma/ Cataracts	
Cancer		Liver disease		Hypo/Hyper thyroid	
Crohn's or Colitis		Mental illness		Irritable Bowel	
Depression		Gout		Kidney disease	
Mental illness		Heart Disease		Liver disease	
Osteoperosis		Heart Murmurs		Ulcers	
Stroke or Aneurysm		High Blood Pressure		Other (please list)	

PERSONAL HEALTH HABITS

Blood Type: _____ Height: _____ Current weight: _____ Ideal weight: _____

SLEEP - How many hours do you sleep per night? _____

Do you have trouble falling asleep? · Yes · No If yes, what keeps you up? _____

Do you sleep straight through the night? · Yes · No

Do you wake feeling refreshed? · Yes · No

Do you have recurring dreams? · Yes · No

STRESS - What level of personal stress are you experiencing right now?

□Minimal □Average □Considerable □Unbearable

The main stressor is: □Financial □Job related □Marriage □Health □Interpersonal

□Unfulfilled expectations □Family □Spiritual

What do you do to deal with stress? _____

ENERGY - Rate your energy on a scale of 1-10 (10 being the most energy) 1 2 3 4 5 6 7 8 9 10

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DIET - How may meals do you generally eat each day? One __ Two __ Three __ More than three __

Average breakfast: _____

Average lunch: _____

Average dinner: _____

What food do you exclude from your diet?

Food _____ Why? _____

_____ _____

What foods do you crave: _____

What temperature liquid to you prefer to drink? __ Hot __ Cold __ Room temperature

Are you satisfied with your diet the way it is now? Why or why not? _____

_____

LIFESTYLE

Do you exercise regularly? YES NO Type: _____ Frequency:_____

How many hours do you work each day? _____ Do you do shift work? YES NO

What are your hobbies? _____

Smoker? YES NO Amount/day? _____ Years smoked? _____ Year stopped? _____

Are you exposed to smoking at home? YES NO Are you exposed to smoking at work? YES NO

Alcohol use? YES NO Type: _____ How many drinks/week: _____

Recreational drug use? YES NO Type: _____ Frequency: _____

How many cups/bottles/glasses do you drink on the average of:

Coffee ____ Tea ____ Water ____ Milk ____ Fruit Juice ____ Soft Drinks ____ Vegetable Juice ____

Herbal Tea ____ Beer ____ Wine ____ Liquor ____

Are you frequently exposed to animals? YES NO What type? _____

Have you ever been exposed to toxic chemicals, solvents, or other hazardous toxins? YES NO

What kind? _____

Thank you for your cooperation, patience, and thoroughness!