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“Reclaim, Restore & Replenish Body Mind & Spirit”
Located at Vital Link Wellness Centre in Grimsby (289) 235-8200

Thank you for taking the time to fill out this form. It will help me get to know the “whole person” and determine the root cause of your concerns. All information is confidential.

ADULT INTAKE FORM

Name______________________________ Date of 1st appointment___________________
Date of Birth _______________(M/D/Y) Present age:____Sex: M / F
Address:__________________________ Town/City:_____________________________.
Postal Code:__________________ Email address:________________________________.
Phone#:(home)______________(work)_______________(cell)__________________.
Where should we leave messages relating to your visits?
Emergency Contact: Name:________________Phone#:___________Relation:____________.
How did you hear about me?____________________________________
Employer_____________________________
Occupation ___________________Hours per week ______________Shift Work ____.
Relationship status: BMarried BSeparated BDivorced BWidowed BSingle BPartnership
Live with: BSpouse BPartner BParents BChildren BFriends BPet BAlone
Name of Spouse/Partner:____________________.
Names and ages of children, if applicable______________________________________.
If you are female, are you currently pregnant or breastfeeding? Yes No

OTHER HEALTH CARE PROVIDERS:
Type of Provider: Family Doctor Type of Provider: __________Type of Provider:__________.
Name: ___________________ Name: ____________________Name: ________________.
Phone: ___________________ Phone: ____________________Phone: _________________.
Blood type: A B AB O
Do you get regular screening tests done by another doctor (Pap, blood tests, etc)? Y N
Date of last PAP/prostate/physical exam:___________________________Doctor:__________.
Date of last dental exam:____________. Dentist:_________________.
Date of last eye exam:____________. Do you wear glasses/contacts?______________.

HEALTH CONCERNS

Please list, in order of importance to you, which health areas you would like to improve:

Chief concerns:	Associated symptoms:	How long has it been going on?	Diagnostic tests, diagnosis, Given by whom:	Previous treatments & results
1.				
2.				
3.				
4.				

What are your short-term health goals? ____________________________________.
____.

What are your long-term health goals? _____________________________________.
____

CHRONOLOGICAL HEALTH HISTORY:

Mother's state of health during her pregnancy, if known:________________________.
How was your birth? Any complications?_____________________________________.
Please indicate below any accidents, injuries, illnesses, hospitalizations, surgeries, complications and any significant stressful event, emotional stresses or traumas (deaths, loss of job, divorce, etc.)
Age 0-4 ____
Age 5-9 ____
Age 10-15____
Age 16-20____
Age 21-25____
Age 26-30____
Age 31-35____
Age 36-40____
Age 41-45____
Age 46-50____
Age 51-55____
Age 56-60____
Age 61-65____
Age 66-70____
Age 71+____
Are any of these continuing to impact your life?___________________________.

MEDICAL HISTORY:

How would you describe your general state of health? Excellent Good Fair Poor
Please indicate your energy level (out of 10, with 10 being the greatest):
in the morning ____ mid-day_______ in the evening: ______

VACCINATION HISTORY

Please indicate what immunizations have you had:

❑ Small pox	❑ Polio	❑ MMR (measles, mumps, rubella)
❑ Hepatitis A ❑ Hepatitis B	❑ DPT (diphtheria, pertussis, tetanus)	❑ Tetanus booster
❑ Haemophilus influenza B ❑ "Flu"	❑ Chicken pox	❑ Other

Did you experience any adverse reactions? ____.

DENTAL HISTORY

Do you have any of the following:

❑ Amalgam (silver) fillings	❑ Dental implants	❑ Root canal

MEDICATION HISTORY:

List any prescription or over-the-counter medications that you are presently taking.

Name of Medication	Daily Dosage	How Long?	Reason for Taking	Drug category
1.				
2.				
3.				
4.				
5.				

Antibiotic use:

When taken:	For how long:	For what condition:

List any nutritional/herbal supplements that you are presently taking.

Name of Supplement	Brand	Daily Dosage	How long?	Reason for Taking
1.				
2.				
3.				
4.				
5.				

Do you frequently use any of the following? (circle) Aspirin/Tylenol/Advil/
Laxatives/Antacids/Cortisone/Diet pills/Hormones/Birth control/Sedatives
Alcohol – how much/ day or week: ______________________________
Tobacco – form and amount/day:_______________________________
Caffeine – form and amount/day: _______________________________
Recreational drugs – what and frequency: _________________________

Family History:
Indicate if a close relative (parent/ child/ sibling) has had any of the following:

Condition:	Who?	Condition:	Who?
Anemia		Diabetes	
Alzheimer's/Dementia		Digestive Disorder	
Arthritis		Heart disease	
Allergies/ Asthma Auto-immune disease		High blood pressure	
Cancer		Kidney disease	
Depression		Seizure disorder/epilepsy	
Other mental illness		Skin Condition	
Drug/ alcohol abuse		Thyroid condition	

Other:____.

- ❑ I don't know my family history.

ALLERGIES
Are you allergic or sensitive to:
Any drugs/medications?___________________________________
Any foods?_______________________________________ ___.
Any environmental triggers?______________________________
Any chemicals?____________________________________ ___.
Any supplements?___________________________________ _.

Review of Systems: Please check the box of any conditions that you have.

HEAD&NECK	EYES&EARS	NEUROLOGICAL
❑ headaches	❑ light sensivity	❑ dizzy/fainting/ seizures
❑ migraines	❑ red/ dry/itchy	❑ tremors/tics
❑ swollen glands/lymph nodes	❑ tearing	❑ numbness/tingling
❑ stiffness	❑ blurred vision	❑ muscle weakness
NOSE&SINUSES	❑ floaters/spots in vision	❑ balance/speech
❑ frequent colds/infections	❑ ringing in ears	GASTRO-INTESTINAL
❑ stuffiness	RESPIRATORY	❑ heartburn/ gas/bloating
❑ hayfever	❑ wheezing	❑ belching/flatus
❑ sinus problems	❑ coughing/sputum	❑ nausea
❑ PostNasalDrip	❑ shortness of breath	❑ excess/poor appetite/thirst
❑ obstruction/snoring	❑ asthma	❑ diarrhea/toxic odour
ENDOCRINE	CARDIOVASCULAR	❑ constipation/hard stool
❑ hormone use	❑ rapid beat/ palpitations	❑ rectal bleeding/itch
❑ thyroid issue	❑ chest pain	❑ hemorrhoids/fissures
❑ fatigue	❑ high blood pressure	______# BMs/day
❑ excessive/difficult sweat	❑ swollen ankles	❑ liver/gallbladder problems
❑ heat/cold intolerance	PERIPHERAL VASCULAR	❑ anemia
❑ night sweats	❑ cold hands/feet	❑ blood/mucus/food in stool
❑ diabetes/hypoglycemia	❑ deep leg pain	circle: stools loose/formed/strain
❑ weight change	❑ varicose veins	stool size & colour:_____________.

FEMALE REPRODUCTIVE	❑ fibroids/ cysts	GENITOURINARY
age of 1st menses:_________.	❑ STD	❑ dark colour/ cloudy urine
age of menopause:________.	❑ vaginal itch/discharge	❑ excessive urination
If still menstruating:	BREAST HEALTH	❑ reduced flow
cycle begins every _____. days	❑ fibrocystic/ lumps	❑ burning/pain/odour
❑ irregular cycles	❑ sore breasts	❑ urgency/ frequency
❑ heavy/light flow	❑ self examination	❑ difficulty stop/starting
❑ cramps/endometriosis	MALE REPRODUCTIVE	❑ kidney stones
❑ clots	❑ hernias	❑ incontinence
❑ yeast infections	❑ sores/lumps/discharge	IMMUNOLOGICAL
PMS:	❑ prostate problems	❑ cancer
❑ tender breasts	❑ disinterest in sex	❑ mononucleosis
❑ bloating	❑ erectile dysfunction	❑ autoimmune disease
❑ emotional lability	❑ low sperm count	MUSCULOSKELETAL
❑ cravings	❑ STD	❑ muscle/joint pain
❑ headache	PSYCHO/SOCIAL	❑ arthritis
❑ acne	❑ depression/SAD	❑ spasms/cramps
# of pregnancies: ___# births:___.	❑ history of abuse	❑ osteoporosis
❑ difficulty conceiving	❑ addiction	SKIN
birth control: ______________.	❑ phobias/fears/compulsions	❑ hives/eczema/psoriasis
❑ abnormal PAP	❑ mood swings/anger	❑ rashes/itch
❑ disinterest in sex	❑ anxiety/panic/nervousness	❑ acne/boils
❑ painful intercourse	❑ learning disability	❑ warts/moles

Diet:

How many glasses/mLs of water per day do you drink? _________. Tap _Bottled _ Filtered

Are there any foods or food groups that you avoid? Y/N

If yes, which ones and why?____________________Food cravings:_________________.

Do you choose organic food? Y/N What types? _________________________________.

Do you consume freshwater fish? Yes No What types? ___________________________.

How much of the following do you consume on a weekly basis?:

wheat products (bread, pastas, Bagels, pastries, cakes etc.)	dairy products (milk, cheese, yogurt etc)	processed/ prepared foods	luncheon/smoked meats
carbonated beverages	candy/sweets	margarine/ vegetable oils	artificial sweetener
fast food	plastic wrap	microwaved food	coffee/tea

Do you cook your own meals? Y / N # of days per week you eat out: _______

Do you eat three meals a day? Y N Describe a typical day's diet:

Breakfast:____

Lunch:____

Dinner:____

Snacks:____

Beverages:____

Lifestyle:
How often do you get outside?________________________.
How often do you engage in physical activity? ‹ 1/wk ‹ 1-3/wk ‹ 3-5/wk ‹ >5/wk
What type of activities, and at what intensity?
____
____
____
Do you have any difficulty falling asleep? ‹ Y/N
Do you wake during the night? Y/N If yes, how often? _________________
Do you feel well-rested when you wake up? ‹ Y/N
How many hours of sleep do you get at night? ____Is it enough?___________________
Do you have a religious or spiritual practice? Y/N If yes, what?____________________.
Do you read? Y/N How many hours per week?____.
Do you enjoy your work? Y/N
Do you take vacations? Y/N
Have you traveled outside of Canada in the last 5 years? Y/N
If yes, when and where:____
Have you been camping in the last 5 years, or do you go camping frequently? Y/N

Environment:
Please describe your home: location, if old or new building, i.e., new construction, older construction, damp or moldy, etc.
Do you have specialized air filtration at home? Yes No
Do you live in the city or country?
Do you work in an office building? Y/N. Do the windows open? Y/N
Are you currently exposed to second hand smoke? Y/N
Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals, (lead, mercury, cadmium, arsenic, etc.) while at home, work or traveling? YesBB No BBAre you regularly exposed to toxins and other hazards, Electro-Magnetic Fields, or loud noise (work, home, hobbies, etc.)? Please describe.____________________

How would you describe the emotional climate of your home?
____
Are you sexually active? Y/N Preference: Heterosexual __Bisexual _Homosexual ___
Do you use birth control? Y/NIf yes, what type of birth control?_______________________
Are you in a happy, supportive relationship? Very __Mostly ___Somewhat ___Not___
Rate your stress level (please circle): Minimal Average High Very high Unbearable
What areas of your life contribute most to your stress?
Work Health Family Financial Interpersonal Spiritual Unfufilled expectations Other:
How well do you handle these stresses? What do you do to deal with stress?____.
When was your last vacation? _______ How often do you take a vacation?_________
What do you enjoy most in your life?____.
What are your main interests or hobbies?_____________________________________
What do you worry about most in your life?___________________________________
What nurtures you?____

On a scale of 0 -10, how satisfied are you with the following areas of your life? (0 being not satisfied, and 10 being extremely satisfied)_____ Career/Work ______Family
_____ Personal Growth_____ Health _____Friends ______Money_____ Love
______Physical Environment _____ Fun/Recreation______Diet_____ Lifestyle

Commitment:
The primary goal of naturopathic medicine is to identify and address the underlying cause of symptoms. Treating the root of illness and maintaining health does not occur overnight; healing is a process that takes time. It requires commitment to making lifestyle changes and following treatment protocols. On a scale of 1-10, how would you describe your level of commitment at this time? (0=not committed, 10=fully committed)
0 1 2 3 4 5 6 7 8 9 10
What behaviours or lifestyle habits do you currently engage in that you believe support your health?
Please list.____.
____.
What behaviours or lifestyle habits do you currently engage in that you believe are destructive to your health? Please list.____.
____.
What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to the treatment plan that you & I will be creating? ____.
Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?______________________________________.
What expectations do you have of me personally as your physician?
____.
Is there anything that you feel is important that has not been covered?
____.
Thank-you for filling out this lengthy questionnaire; I'm looking forward to working with you to restore balance to your health naturally!
Elly