RICHMOND HILL NATUROPATHIC CLINIC
10168 Yonge Street, Suite 102,
Richmond Hill, ON, L4C1T6

Phone: (905) 237-8521
Fax: (905) 237-8531
www. richmondhillclinic.com

Adult Intake Form

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

Name____ Date ______________________

Date of birth: Date ________ Month _____________ Year______________ Sex / Gender _____________________

Address____

____

____

____ Postal code _______________

E-mail Address ____

Home Telephone Number ________________________________ Work ____________________

May we leave messages relating to your visits? ☐Y / ☐N Which Phone Number? ____________________

Emergency contact: Name______________________ Phone number _______________ Relation ______________

How did you hear about our Clinic? Please check one of the following:

☐RHNC Website	☐Medical Doctor
☐RHNC Open House	☐Media/TV Article
☐RHNC Staff	☐Corporate Health/Wellness Event
☐RHNC Patient	☐Newsletter Delivery to Residence
☐Friend	☐RHNC Information Session
☐Family	☐Other ______________________

Referred by ____

Referred to ____

(Naturopathic Doctor at RHNC)

Other health care providers you are seeing:

1. Name ______________________	2. Name ______________________	3. Name ______________________
Address ______________________	Address ______________________	Address ______________________
______________________________	______________________________	______________________________
Phone (______)________________	Phone (______)________________	Phone (______)________________
Fax (______)________________	Fax (______)________________	Fax (______)________________

Last physician or health practitioner seen ____ When ______________

When was your last physical exam? __________________________________ Were blood tests done? ☐Y / ☐N

Blood type ____

If you are female are you currently pregnant? ☐Yes / ☐No

What is your main reason of coming today? ____

____

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

1. ____How long? _____________
2. ____How long? _____________
3. ____How long? _____________
4. ____How long? _____________
5. ____How long? _____________

What kind of conventional treatment have you received?

____

____

____

Please mark all of the following complimentary health care practitioners you have seen:

☐Naturopathic Doctor ☐Chiropractor ☐Acupuncturist ☐Massage Therapist ☐Osteopath ☐Other: ____________

What was the therapy and what were the results?

____

____

MEDICAL HISTORY

How would you describe your general state of health? ☐Excellent ☐Good ☐Fair ☐Poor

How often do you get colds, flus, sore throats in a year? ____

What is your current level of energy from 1 to 10 (10 = the best you have ever felt): ______________________

What is your current approximate weight _________One year ago _________ Ideal weight? _________ Height _______

Please list 5 most significant stressful events in your life:

1) ____ Date: ___________
2) ____ Date: ___________
3) ____ Date: ___________
4) ____ Date: ___________
5) ____ Date: ___________

Are any of these situations continuing to impact your life? ☐Y / ☐N (*If yes please circle the number.*)

Are you currently working with a professional counselor, psychologist, social worker, pastor or other therapist? ____

Have you in the past / when? ____

Please indicate any serious conditions, illnesses or injuries and any hospitalizations, along with approximate dates.

____

____

____

____

Do you have any allergies (medicines, herbs, food, environmental, etc.)? ____

____

____

Please list all <u>current</u> medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

____

____

____

____

Please list <u>past</u> prescription medications.

____

____

____

____

How many times have you been treated with antibiotics? ____

Do you frequently use any of the following?

☐Aspirin ☐Laxatives ☐Antacids ☐Diet pills ☐Birth control: pills / implants / injections (circle)

Alcohol—how much/day or week ____

Tobacco—form and amount/day ____

Caffeine—form and amount/day____

Recreational drugs—what and how often ____

Have you been treated for alcoholism? ☐Y / ☐N How often? ____

Have you been treated for drug dependence? ☐Y / ☐N How often? ____

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Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A
☐ Tetanus booster; when? ______________________________	☐ "Flu"	☐ Hepatitis B
☐ MMR (measles, mumps, rubella)	☐ Polio	☐ Smallpox

Other ____

Please indicate if any caused adverse reactions: ____
____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? ☐Y / ☐N

DIET

Do you have any food allergies or intolerances? Please list.

____
____
____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____
____
____

Do you eat 3 meals daily? ☐Y / ☐N

Describe a typical day's diet:

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Beverages (and total quantity) ____

Have you ever fasted? ☐Y / ☐N What type of fast did you do (i.e. juice or water)? ___________________________

FAMILY HISTORY

Indicate if a close relative (parent, grandparent, child, sibling) has had any of the following:

Condition	Please indicate which family member
Allergies	
Asthma	
Heart Disease	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other Mental Illness	
Drug Abuse/Alcoholism	
Kidney Disease	
Stroke	
Tuberculosis	
Other ______________________	

☐ I don't know my family medical history

HOME/WORK ENVIRONMENT

Marital status ____ Number of children _______________________

Occupation ____

Do you enjoy your work? ☐Y / ☐N Do you take vacations? ☐Y / ☐N

Have you travelled outside of Canada in the last 5 years? ☐Y / ☐N

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

____

____

Hobbies ____

Who do you currently live with? ☐Spouse ☐Partner ☐Parents ☐Friends ☐Children ☐Alone

Are you currently in a happy and supportive relationship? ☐Very ☐Mostly ☐Somewhat ☐No

How would you describe the emotional climate of your home? ____

____

What do you enjoy most in your life? ____

____

What do you worry about most in your life? ____

____

What nurtures you? ____

Do you have a religious or spiritual practice? ____

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PERSONAL HABITS

Do you exercise regularly? ☐Y / ☐N What do you do for exercise, how much, how often (times x week)?

____

____

How is your body temperature, compared to others? ☐Warmer ☐Cooler ☐Average

Do you have any difficulty perspiring? ☐Y / ☐N Does you sweat has a strong odour? ______________________

Do you perspire when exercising? ☐Lightly ☐Moderately ☐Heavily

Do you perspire at times other than when you exercise? When? _____________________________________

Do you experience night sweats? ☐Y / ☐N How frequently? _______________________________________

On a scale of 1-10, how would you rate the quality of your sleep (10 being great) ___________________________

Do you have problem falling asleep? ☐Y / ☐N Staying asleep? ☐Y / ☐N How much do you sleep? _________ hours

How many hours do you think you need _______________ Do you wake up refreshed? __________________

Do you nap or rest horizontally throughout the day? ☐Y / ☐N For how long? ___________________________

Do you watch television? ☐Y / ☐N How many hours / day? ____

How do you learn? ☐I read ☐I listen (lectures) ☐Television ☐Through stories ☐Very visual

OCCUPATIONAL / HOUSEHOLD

Are you exposed to significant tobacco smoke (work, home, etc.)? ☐Y / ☐N

Are you frequently exposed to animals (work, pets, etc.)? ☐Y / ☐N

How is your home heated? ____

Is your home damp or moldy at all? ☐Y / ☐N

Do you have any specialized air filtration system at home? ☐Y / ☐N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

____

____

What do you use for drinking water? ☐Tap water ☐Bottled Water ☐Filtered Water ☐Reverse Osmosis

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

____

____

____

Thank you for taking time to fill in this questionnaire. It will be a valuable resource to evaluate your current health.

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