Sarah Bennett ND
Summerhill Health Centre
99 Crown's Lane, Toronto, Ontario M5R 3P4

ADULT INTAKE FORM

Please print clearly and fill out this form to the best of your ability. It will help to assess your present health and will assist in facilitating the healing process.

Name: _____ Date:_____

Date of Birth: (mm/dd/yy): ____/____/_____

Address: _____ Age:____

_____ Gender: _____

_____ Present weight: _____

Phone (home):(_____)_____ Present height: _____

Phone (work): (_____)_____ Ethnicity: _____

May we leave messages relating to your visits? Y/N

E-mail Address: _____

Marital Status: (circle one) married / separated / divorced / widowed / single / other: _____

Occupation: _____ (circle one) full time / part time / retired / student

Emergency Contact:

Name: _____ Relation: _____ Phone:(_____)_____

How did you hear about our clinic? _____

Referred by: _____

Names of other health care practitioner you are seeing:

Name: _____	Name: _____	Name: _____
Practitioner: _____	Practitioner: _____	Practitioner: _____
Address: _____	Address: _____	Address:_____
_____	_____	_____
Phone: (_____)_____	Phone: (_____)_____	Phone: (_____)_____

CHIEF HEALTH CONCERNS

What is your primary health concern: _____

List other health concerns in order of importance to you:

2. _____
3. _____
4. _____
5. _____

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MEDICAL HISTORY

Describe your present general state of health: _____

Please indicate any serious conditions, illnesses or injuries, and any surgeries or hospitalizations (provide approximate dates):

1. _____
2. _____
3. _____
4. _____
5. _____

List any allergies (medicines, environmental, etc.) you have:

_____

_____

List all names of *prescribed medication* currently being taken:

Medication	Dose (i.e. mg)	Frequency (#times/day)	Since How Long	Adverse Reactions/ Allergies (describe)

List all *over the counter medication* that you take (e.g.: Aspirin, Tylenol, Tums, etc.). Include dosage and frequency and any adverse reactions/allergies to medications:

1. _____
2. _____
3. _____

List all vitamins, minerals, botanical (herbal) medicines, Asian medicines (Chinese Patent drugs), or homeopathic remedies that you are currently taking :

_____

_____

_____

Do you use any recreational drugs? Y/N (If yes, indicate what type and frequency of usage):

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Indicate the vaccinations have you received:

- ❑ Chicken pox (Varicella)
- ❑ Cholera
- ❑ DTP (Diphtheria/Tetanus/Pertussis)
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Influenza (flu shot)
- ❑ MMR (Measles/Mumps/Rubella)
- ❑ Meningococcal (meningitis)
- ❑ Pneumococcal
- ❑ Polio
- ❑ Travel Vaccinations
- ❑ Rabies
- ❑ Typhoid
- ❑ BCG (Tuberculosis)
- ❑ Yellow Fever
- ❑ Don't know

Have you ever experienced any adverse reactions to the above vaccinations? Y/N (Describe):

PREVIOUS HEALTH HISTORY/FAMILY HISTORY:

Check mark if you or any of your family members indicated has/had any of the following diseases.
Circle L = Living or D = Deceased, and fill in the age.

CONDITION	Mother L/D:___	Father L/D:___	G-mother (M) L/D:___	G-father (M) L/D:___	G-mother (F) L/D:___	G-father (F) L/D:___
Alcoholism						
Allergies						
Arthritis						
Asthma						
Condition						
Cancer (type?)						
Diabetes						
Depression						
Drug Abuse						
Heart disease						
High Blood Pressure						
Kidney disease						
Liver disease						
Mental Illness						
Stroke						
Thyroid (hyper/hypo)						
Other:						

List diseases/conditions that apply to your siblings:

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Sister: _____ Brother: _____

Sister: _____ Brother: _____

Sister: _____ Brother: _____

- I don't know my family history

LIFESTYLE:

What did you eat/drink in the past 24 hours:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

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

If yes, describe: _____

Do you drink alcohol? Y/N (If yes, indicate what type of alcohol and how many glasses per week):

_____

Do you smoke? Y/N (If yes, indicate for how long, and how many cigarettes/cigars per day):

_____

What level of personal stress are you experiencing at the present moment? (circle one):

none / average/ considerable/ unbearable

What is/are your major stressor(s)?

- ❑ financial
- ❑ job related
- ❑ marriage
- ❑ personal health
- ❑ family members
- ❑ family issues (i.e. death)
- ❑ interpersonal
- ❑ spiritual
- ❑ other: _____

On average, how many hours of sleep do you get per night? _____

On average, how many hours do you work each day? _____

Does anyone else in your household smoke? (circle one) Y/N

Do you own any pets? Y/N (Indicate what type):

_____

Do you exercise? Y /N (Indicate what type of exercise and how long):

_____

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List your hobbies: _____

Are you sexually active? Y / N Method of contraception:_____

If you are a female are you: Pregnant? Y/N or Breast feeding? Y/N

Have you ever been exposed to toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc.) while at work, home or traveling?

Yes □ No □

Are there any other medical conditions or health concerns?

_____

_____

CONTEXT OF CARE OVERVIEW

1. Why did you choose to come to this clinic?

2. What do you know about Naturopathic Medicine?

3. What are your expectations of Naturopathic care?

4. What expectations do you have of me personally as your physician?

5. What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

6. What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols?

7.Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

Thank you for taking the time to complete these forms. Complete answers to all of the above questions will help provide you with most effective naturopathic treatment.