Kinesis Health Associates

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Doctor of Naturopathic Medicine

Adult Intake Form

All Information is confidential

Contact Information

Full Name: _____ Date: DD/MM/YYYY

Age _____ Date of Birth : DD/MM/YYYY Preferred Pronoun: ☐ He ☐ She ☐ Other _____

Address: _____ Phone (Home): (____)_____
_____ Phone (Work): (____)_____ ext:____
_____ Phone (Cell): (____)_____

May we leave messages related to your visits? (Y / N), Which number: (____)_____
Email Address: _____

Emergency Contact: Name : _____ Relation: _____
Emergency Contact Phone Number: (____)_____

How would you identify your gender identity (please check all that apply): ☐ Male ☐ Female ☐ Transgender
☐Alternative: _____ ☐ Prefer not to disclose

Family Doctor's Name: _____ Phone: (____)_____

Other Health Care Providers you are seeing:
1. Name: _____ Specialty: _____ Date of last visit: _____
2. Name: _____ Specialty: _____ Date of last visit: _____
3. Name: _____ Specialty: _____ Date of last visit: _____

Permission to consult with your health care providers? ☐ Yes ☐ No

How did you hear about our clinic:_____

Have you ever consulted a Naturopathic Doctor before? ☐ Yes ☐ No
Were the treatment interventions you tried, successful? ☐ Yes ☐ No

Health Goals

What are your health goals, in order of importance to you:
Please state if there has been prior diagnosis of this problem, and if so, what?

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

Medical History

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

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

Are you currently pregnant? ☐ Yes ☐ No If yes, what is your due date: _____
Are you currently lactating? ☐ Yes ☐ No

Are you currently on birth control? ☐Yes ☐ No If yes, ☐ Pill ☐ IUD/Implant ☐ Ring ☐ Injections

Please indicate any **diagnoses, serious conditions, illnesses, or injuries** you currently or previously had, as well as any hospitalizations, along with approximate dates:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Do you have any known **allergies/sensitivities** (medications, dietary, environmental, etc.)?

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please list all **<u>current</u> medications/supplements/natural health products** (including over-the-counter medications, herbs, vitamins, etc.) and dosages:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

7. _____ 8. _____

Please list any **<u>past</u> prescription medications or supplements/natural health products**:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

Please indicate which immunizations you have had:

☐ DPT (Diphtheria, Pertussis, Tetanus) ☐ Tetanus booster, Date: _____ ☐ Gardasil HPV
☐ MMR (Measles, Mumps, Rubella) ☐ Polio ☐ Haemophilus Influenza B ☐ Small Pox
☐ Hepatitis A ☐ Hepatitis B ☐ Annual Flu Shot

Do you get regular screening tests done by another doctor/health care provider (blood work, Pap screens etc.)
☐ Yes ☐ No Date of your last blood work: _____

Environment

Occupation: _____
Do you enjoy your work? □ Yes □ No

How stressful is your work, or other aspects of your life? _____

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

How many mercury (silver) fillings do you have? _____ Number of root canals: _____

Are you regularly or have you ever been exposed to solvents, heavy metals, fumes, pesticides/herbicides, or Are you particularly sensitive to perfumes, gasoline, or other vapours (such as from new furniture, carpets, paints, etc.)?_____

Lifestyle

Hours of sleep/night? _____ Quality of sleep? _____ Do you feel rested on waking? _____

Exercise (type, duration and frequency): _____

Water (glasses/day): _____
Do you currently consume any of the following. If yes, what form and amount per day:
Alcohol _____
Tobacco _____
Caffeine _____
Recreational drugs _____

Hobbies: _____

Family History

Please indicate if any of the following concerns are known to be present in your family's medical history and who is affected (self, father, mother, sibling, grandparent):

□ Alcoholism/Addiction: _____ □ Heart Disease: _____
□ Aneurysm: _____ □ Hepatitis: _____
□ Arthritis: _____ □ Kidney Disease: _____
□ Cancer: _____ □ Stroke: _____
□ Diabetes: _____ □ Osteoporosis: _____
□ Depression/Mental Illness: _____ □ Other: _____
□ High Blood Pressure: _____ □ Other: _____

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

Review of Symptoms

Weight: _____ Height: _____

Please **circle** any of the following symptoms that you experience:

Skin:
Itching
Hives
Rashes
Easy Bruising
Changing Moles
Eczema
Psoriasis
Acne
Loss of Pigment
Hyperpigmentation

Hair & Nails:
Recent Hair Loss
Alopecia
Changes in Texture
Nail Infections
New Hair Growth

Eyes:
Blurry Vision
Excess Tearing
Dryness
Discharge
Redness
Itching
Pain
Tunnel Vision

Ears:
Pain
Ringing/Tinnitus
Discharge
Hearing Loss
Recurrent Infections

Nose & Sinus:
Runny/Discharge
Nosebleeds
Congestion
Allergies

Mouth & Throat:
Sore Throat
Bleeding Gums
Toothache
Canker Sores
Cold Sores
Hoarseness

Neck:
Pain
Stiffness
Swollen Lymph Nodes
Goitre

Axillae/Underarm:
Tenderness
Swelling
Lumps/Masses
Rash

Lungs:
Wheezing
Shortness of Breath
Cough
Phlegm
Asthma
Bronchitis

Chest/Heart:
Pain
Palpitations
High Blood Pressure
Heart Murmur

Vascular:
Cold Limbs
Swelling in Extremities
Numbness
Tingling
Discolouration of Extremities
Varicose Veins
Blood Clots
Leg Ulcers
Pain in Legs

Digestive:
Heartburn
Constipation
Diarrhea
Hemorrhoids
Blood in Stool
Bloating
Nausea
Abdominal Pain
Gas

Musculoskeletal:
Joint Pain
Joint Swelling
Joint Stiffness
Back Pain
Arthritis
Muscle Spasms
Restless Legs

Neurological:
Seizures
Fainting
Stroke
Muscle Weakness
Tremor/Tic
Paralysis
Numbness
Dizziness
Memory Loss
Balance Issues

Endocrine:
Fatigue
Intolerant to Heat
Intolerant to Cold
Excessive Sweating
Hot Flashes
Night Sweats
Low Blood Sugar

Urinary:
Pain on Urination
Incomplete Urination
Kidney Stones
Blood in Urine

Immunity:
Serious Infection
Warts
Hepatitis
Parasites
Yeast Overgrowth
Fungal Infections
Cancer
Frequent Colds
Autoimmune Disease

Mental Health:
Anxiety
Depression
Bipolar Disorder
Schizophrenia
Psychosis
Personality Disorder
PTSD
Obsessive Compulsive
Body Dysmorphia
Anorexia
Bulimia
Binge Eating
Substance Abuse

Female Reproductive:
Irregular Cycles
Painful Cycles
Bleeding/Spotting between Periods
PMS
Painful Intercourse
Low Libido
Yeast Infections
STI
Vaginal Discharge
Vaginal Odor
Vaginal Dryness

Male Reproductive:
Testicular Masses
Testicular Pain
Low Libido
STI
Discharge
Prostate Issues
Erectile Dysfunction