TRACY PALMER
NATUROPATHIC DOCTOR

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www.tracypalmernd.com

# Adult Intake Form

*(Please print clearly)*

Date: _____

**General Information:**

Name _____ Gender _____

Age_____ Date of birth _____/_____/_____ (mm/dd/year)

Address _____City _____

Province _____ Postal Code _____

Phone number _____ (home) _____ (work)

_____ (cell) Email address _____

May we leave a message regarding appointments? Y / N

Would you like your email entered to receive our quarterly naturopathic e-newsletter? Y / N

Occupation _____ Circle one: Full time/Part time/Retired/Student

Marital Status: Married/ Separated/ Divorced/Widowed/Single/Other

**Emergency Contact**:

Name _____ Relation _____ Phone _____

How did you hear about the office? Circle one: Internet/ Yellow pages/ Family/ GP referral/ Other, please specify _____

Name and Phone number of your family doctor: _____

_____

Other health care providers you are seeing and for what concerns:

| 1. | 2. | 3. |
|---|---|---|
| | | |
| ( ) | ( ) | ( ) |

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

If you are female, are you currently pregnant? Y/ N

Main reason for visit _____

_____

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Please list any other health problems that are of concern to you, in order of importance:

1. _____ How long? _____
2. _____ How long? _____
3. _____ How long? _____
4. _____ How long? _____

**Context of Care Overview:**

*The answers to the following questions will help me to meet your expectations and gain a greater understanding of your current health. Your time and thoughtfulness in completing this overview is greatly appreciated.*

1) What 3 expectations do you have from this visit with me?

2) What long-term expectations do you have from working with me?

3) What expectations do you have of me personally as your doctor?

4) What behaviours or lifestyle habits do you currently engage in regularly that you feel *support* your health? Please list.

5) What behaviours or lifestyle habits do you currently engage in regularly that you feel are *contributing* to your health concerns? Please list.

6) What potential obstacles do you foresee when addressing any lifestyle factors that are interfering with your health and in following the treatment plan that we suggest?

7) What is your present level of commitment to address any underlying lifestyle factors that may be contributing to your health concerns? Please rate from 1 – 10, with 10 = 100% committed)

   1 2 3 4 5 6 7 8 9 10

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**Family History:**

Indicate if any immediate family member(s) are presently or have previously been affected by any of the following medical conditions:

| Condition | Family member(s) affected and outcome |
|---|---|
| Severe allergies (anaphylaxis) | |
| Heart Disease (heart attacks, strokes, arrhythmias) | |
| High Blood Pressure | |
| Cancer (specify type) | |
| Diabetes | |
| Thyroid Disease | |
| Asthma | |
| Depression, anxiety, and/or other mental illnesses | |
| Suicidal tendencies | |
| Alcoholism/Drug Addiction | |
| Kidney Disease | |
| Other | |

_____ Check here if you do not know your family history

**Personal Health History:**

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

Please list all of your past and/or current medical conditions, injuries, and hospitalizations, along with approximate dates:

_____

_____

_____

_____

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Do you have any allergies (medications, environmental, foods, etc)? If so, please indicate allergen and reaction experienced:

_____

_____

Please list all current medicines that you are taking (prescription, over-the-counter, vitamins, herbs, homeopathics, etc).

| Medicine (including brand, dose, frequency where applicable) | For how long? |
|---|---|
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |
| | |

Please indicate with an "X" which immunizations you have had:

| | | | |
|---|---|---|---|
| | DPT (diphtheria, pertussis, tetanus) | | Polio |
| | Tetanus booster, when?_____ | | Haemophilus influenza B |
| | MMR (measles, mumps, rubella) | | "Flu" |
| | Hepatitis A | | Smallpox |
| | Hepatitis B | | Other_____ |

Did you experience any adverse reactions to these immunizations? If so, what were they?

_____

Do you now, or have you ever smoked cigarettes/tobacco? If yes, what quantity? _____

If you consume alcohol, how much alcohol do you consumer per week? _____

Do you use recreational drugs? If yes, which ones and how often? _____

Do you consume caffeine? If yes, how much? _____

Do you exercise regularly? Yes No What do you do for exercise, how much, how often?

_____

**Emotional Health**

Are you able to find joy in some/all aspects of your life? Yes No

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Please rate your emotional health via the following scale and circle the corresponding number: (1=unstable, difficulty coping; 10=happy, stable)

1 2 3 4 5 6 7 8 9 10

How stressful is your everyday life (1=stress-free; 10=extremely stressful). Circle the corresponding number

1 2 3 4 5 6 7 8 9 10

Please provide a brief description about your home life and your general emotional state

_____

_____

## Review of Systems

### General Information

| | | | | |
|---|---|---|---|---|
| Strength | Excellent | Good | Average | Poor |
| Exercise tolerance | Excellent | Good | Average | Poor |

Average weight _____ Recent/Past weight loss or gain _____

Please place a checkmark beside any condition you are presently experiencing or that you have experienced in the past. If the symptom was in the past, please indicate by placing a "P" beside the checkmark.

### Eyes/Ears/Nose/Throat

| | | | |
|---|---|---|---|
| ❍ Headaches | ❍ Double vision | ❍ Nose bleeding | ❍ Dental problems |
| ❍ Vertigo | ❍ Tearing | ❍ Frequent colds | ❍ Bleeding gums |
| ❍ Light headed | ❍ Blind spots | ❍ Nasal congestion | ❍ Dentures |
| ❍ Neck stiffness | ❍ Eye Pain | ❍ Cataracts | ❍ Multiple fillings (3+) |
| ❍ Neck Pain/Tenderness | | ❍ Lumps/masses found in neck | |

Other (please specify): _____

### Cardiovascular System

| | |
|---|---|
| ❍ Chest pain | ❍ Shortness of breath on exertion |
| ❍ Palpitations | ❍ Shortness of breath while lying down |
| ❍ Fainting | ❍ Shortness of breath at night |
| ❍ Heart murmurs | ❍ Swelling of ankles, feet, or hands |
| ❍ Varicose Veins | ❍ Leg pain worse with exercise and relieved by rest |
| ❍ High blood pressure | ❍ Cyanosis (bluish tone to skin) |
| ❍ Phlebitis | ❍ Family history of heart disease |

Date of last ECG: _____

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Other cardiovascular concerns (please specify):_____

**Respiratory System**

- ❍ Chest pain when breathing
- ❍ Shortness of breath
- ❍ Wheezing
- ❍ Environmental allergies
- ❍ Tuberculosis (or exposure to TB)
- ❍ Sinus infections
- ❍ Chronic nasal discharge
- ❍ Fever or night sweats
- ❍ Recurrent respiratory infections
- ❍ Coughing up blood
- ❍ Persistent cough
- ❍ Asthma

Date of last chest X-Ray and/or TB test: _____

Other respiratory/chest/breathing concerns (please specify): _____

**Gastrointestinal System**

- ❍ Change in appetite
- ❍ Difficulty swallowing
- ❍ Frequent indigestion
- ❍ Hemorrhoids
- ❍ Frequent nausea
- ❍ Frequent constipation
- ❍ Frequent heartburn
- ❍ Frequent abdominal pain
- ❍ Frequent flatulence (passing gas)
- ❍ Recent change in bowel habits
- ❍ Blood in stool
- ❍ Vomiting blood
- ❍ Frequent diarrhea
- ❍ Jaundice (yellowing of the skin or eyes)

Other gastrointestinal concerns (please specify):_____

**Genitourinary System**

- ❍ Urinary urgency
- ❍ Frequent urination
- ❍ Pain on urination
- ❍ Frequent urination at night
- ❍ Blood in the urine
- ❍ Urinary incontinence
- ❍ Frequent bladder/kidney infections
- ❍ Kidney stones
- ❍ Dribbling of urine
- ❍ Change in libido
- ❍ Impotence
- ❍ Infertility
- ❍ Genital discharge
- ❍ Sexually transmitted infection

Other urinary or genital concerns (please specify): _____

**Females only**: Age of onset of menses_____
Length of cycle (days) _____ Duration of bleeding _____
Date of last menstrual period _____
Number of pregnancies _____ Number of live births _____
Please check any of the following that you experience:

- ❍ Heavy menstrual bleeding
- ❍ Menstrual cramping and pain
- ❍ Bleeding between cycles
- ❍ Missed periods
- ❍ Vaginal discharge
- ❍ Pain during intercourse
- ❍ Breast lumps
- ❍ Breast tenderness
- ❍ Nipple discharge
- ❍ Post-menopausal bleeding

Are you presently or have you ever been on birth control? Y/N
Which one, and for how long? _____

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Date of onset of menopause/menopausal symptoms: _____

**Skin/Hair/Nails**

- ❍ Frequent/chronic skin rashes
- ❍ Change in texture of skin
- ❍ Skin itching
- ❍ Skin discolouration
- ❍ Acne
- ❍ Changes in hair growth
- ❍ Hair loss
- ❍ Nail changes (breaking, pitting, etc)
- ❍ Changes in moles, freckles, birth marks
- ❍ Excessive moisture or dryness of skin

Other skin, hair, or nail concerns (please specify): _____

**Musculoskeletal System**

- ❍ Muscular weakness
- ❍ Muscle wasting
- ❍ Muscle cramps
- ❍ Bone pains
- ❍ Muscle pain or swelling
- ❍ Restricted movement
- ❍ Decreased flexibility
- ❍ Redness or heat of muscles and/or joints

Other muscle or bone concerns (please specify): _____

**Neurological/Psychological System**

- ❍ Convulsions
- ❍ Paralysis
- ❍ Tremor
- ❍ Loss of coordination
- ❍ Unusual sensation (pins & needles, numbness)
- ❍ Memory changes
- ❍ Speech difficulties
- ❍ Nervousness
- ❍ Depression
- ❍ Emotional problems
- ❍ Anxiety
- ❍ Panic attacks
- ❍ Hallucinations
- ❍ Previous psychiatric care

Other neurological/psychological concerns (please specify): _____

**Hematological/Immune/Endocrine Systems**

- ❍ Increased thirst
- ❍ Bleeding tendency
- ❍ Previous transfusions
- ❍ Hormone therapy (thyroid medication, hormonal replacement, diabetic medication, etc.)
- ❍ Intolerance to heat or cold
- ❍ Anemia
- ❍ Local or general lymph node enlargement/tenderness

Other blood-related, immune, or hormonal concerns (please specify): _____

Is there anything that you feel is important that has not been covered by this form? Please explain

_____

_____