White Pines Naturopathic Clinic (WPNC)
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Naturopathic Intake Form - Adult

Full Name: __________________________________ Date of Birth _________ Age ____ Today's date ________
Address ____City ________________ Postal Code__________
Phone (Home) ____________________________________ (Alternate) _____________________________________
E-mail ____ Do not send newsletters ☐
Occupation/Employer ____ Hours per week _______________
Marital Status: M D W S Sep. # of Children _____ Ages ___________________________________
How did you hear about the clinic? __________________ Have you seen an ND in the past? ________________
Emergency Contact Name ________________________________ Relationship ____________________________
Phone ________________________ Address ____

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless you authorize me to do so.

Primary health care concerns in order of importance:	**Onset**	**Cause**
1.____	_________________	____________________
2. ____	_________________	____________________
3. ____	_________________	____________________
4. ____	_________________	____________________
5. ____	_________________	____________________
6. ____	_________________	____________________
7. ____	_________________	____________________
8. ____	_________________	____________________

Other Key Health Care Providers

1. ______________________________ 2. ____________________________ 3. ____________________________
________________________________ ______________________________ ______________________________
(____)__________________________ (____) ______________________ (___)________________________

Medications (use extra paper if necessary)

Please list all prescription and over the counter medications that you are ***currently*** taking including the doses.
____
____
____

Please list past prescription medications. ____
____

Please list all vitamins, herbs, remedies, and other supplements that you are currently taking including the doses
____
____

Do you have any allergies to medications, foods or the environment? If so, what to, with what reactions?
____
____Have you ever had an anaphylactic reaction? __________

Personal Overview

1. Reversing illness by treating the underlying causes of disease, and effectively managing healthcare **does not happen overnight**. It requires a commitment to lifestyle change, and following therapeutic protocols. How would you describe your present level of commitment to making changes in your health? Rate on scale from 0-10 with 10 indicating 100% commitment: (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)

2. Please list behaviours or lifestyle habits you engage in regularly that you believe support your health.
____

3. Please list behaviours of lifestyle habits that you engage in regularly that you believe undermine your health.
____

4. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and in adhering to therapeutic protocols that I will be sharing with you? ________________________________
____

5. What is your support system like? Do you have people who will sincerely and consistently support you with the beneficial lifestyle changes you will be making? ____
____

6. What expectations do you have of me personally as your doctor? ___________________________________
____

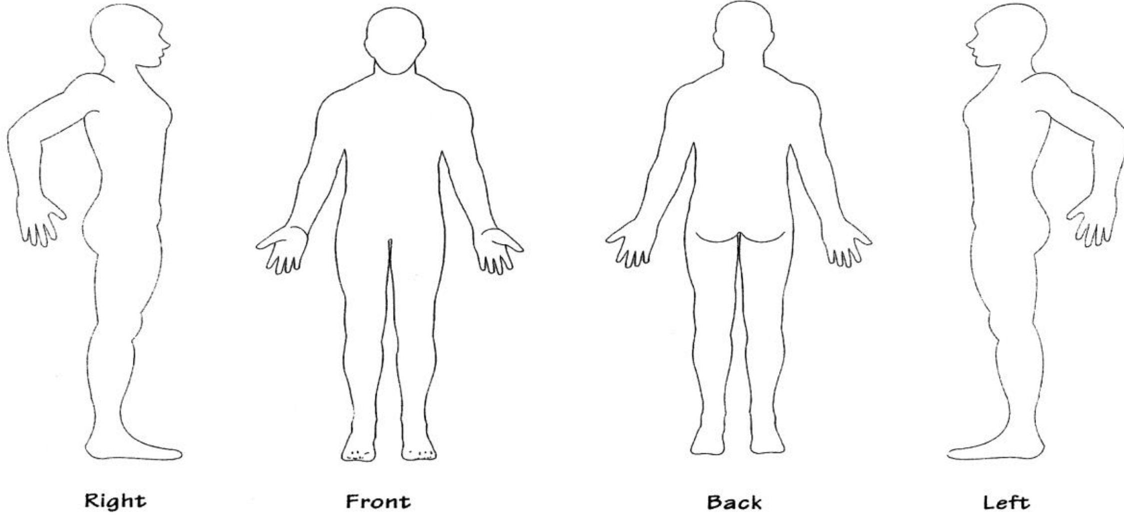
General

Height:_________ Weight:_______ Max Weight:_______ When:_______ Min. Weight:______ When: _____
Weight 1 yr. ago: _______ Ideal Weight _______ Are you happy with your weight (0-10 scale) _____________
On average where would you rate your **energy**? : (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)
What time of day is your energy at its best:_______________________ and worst : ________________________
How is the quality of your **sleep**? : (0%) 0 1 2 3 4 5 6 7 8 9 10 (100%)
Do you sleep soundly? ____ Y ____ N
Do you fall asleep easily? ____ Y ____ N
Do you wake during the night? ___ Y ___N
How often ____ What time(s) ________________
Do you wake refreshed? ____ Y ____ N
Do you fall back to sleep easily? ____Y ____ N
What time do you fall asleep at? _______________
What time do you get up at? _______________
Do you have a regular sleep routine? ___ Y ___ N Do you ever have naps? ___ Y ___ N

Health History

How would you describe your current state of health? Excellent Good Fair Poor
What was your general state of health as a child? Excellent Good Fair Poor

Please mark on the bodies below, the areas that are a problem for you.



Please list any serious conditions, illnesses, injuries, all surgeries and hospitalizations including approx. dates.
____
____
____

Do you have any known contagious diseases at this time? __ Y __N If Yes, what? ______________________

Please list any X-rays, CT scans, blood work or other studies that you have had in the past 2 years.
____

If appropriate, may we requisition these for our records? ____ Y ____N

Are you currently being treated for a health concern by any other healthcare providers (licensed or not)? Please explain.____
____

Do you, or have you experienced depression, mania, anxiety, panic attacks, OCD or other psychological imbalances? Please circle or note and indicate if Past or Current with dates ____________________________
____

Please list the most significant, stressful events in your life/history. Are any of these situations continuing to impact your life?

1.____ date ______________Y/N
2. ____ date ______________Y/N
3.____ date ______________Y/N
4. ____ date ______________Y/N
5. ____ date ______________Y/N
6. ____ date ______________Y/N

Lifestyle

What is your general outlook on life?____

What do you enjoy most in your life? ____
Main interests and hobbies ____
Do you exercise? ___Y ___N What do you do & how often? ____________________________________
What do you do regularly for rest, relaxation & fun? ______________________________________
Are you, or have you been exposed to toxins or other hazardous materials (work/ home/ hobbies etc.)? Please describe ____
____
How would you describe the emotional climate in your home? _________________________________
How stressful is your life? ____
How well do you handle the stressors in your life? ____
For the following, please **circle "Y" for yes, "N" for no or "P" for past.**

Do you use recreational drugs? If so, which ones? #_____/week	Y N P	Do you watch TV? hrs___/day, ___/week Do you read? # hrs____/day, ____/ week	Y N P
Do you drink alcohol? How many per #____day, #_____week	Y N P	Do you drink cola/soft drinks/pop? How many #/____ day, ____/ week	Y N P
Do you drink black tea? How many cups/____day, ____ / week	Y N P	Do you have a religious or spiritual practice?	Y N P
Do you smoke tobacco? #___/day, ___ /week. For how long?___	Y N P	Do you drink coffee? How many cups____/day, _____/week	Y N P
Have you ever been treated for addiction?	Y N P	Do you eat 3 meals a day?	Y N P
Are you exposed to 2nd hand smoke?	Y N P	Do you eat refined sugar?	Y N P
Do you enjoy your work?	Y N P	Do you add salt to your food?	Y N P
Do you take vacations?	Y N P	Do you eat out often? # ____/wk___/mo	Y N P
Did you have antibiotics as a child?	Y N	# of antibiotics in the last year ________	Y N

What immunizations have you had?

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Haemophilus influenza B
- ☐ MMR (measles, mumps, rubella)
- ☐ Chicken Pox
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Hepatitis C
- ☐ Other: ______________________________
- ☐ Flu shot
- ☐ Polio
- ☐ Smallpox

Please indicate any adverse reactions you have experienced from an immunization: ____________________

Family History by Relative	Age if Living	Age at Death	Ailment(s)
Mother			
Father			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			

Paternal Grandfather			
Maternal Aunts/Uncles			
Paternal Aunts/Uncles			
Siblings			
Siblings			
Siblings			

Review of Systems

Please indicate whether you experience, or have experienced in the past any of these symptoms, **Y**es/ **N**o/ **P**ast

Skin

Eczema, hives?	Y N P	Lumps?	Y N P
Acne, boils?	Y N P	Hair loss?	Y N P
Itching?	Y N P	Dryness?	Y N P
Colour Change?	Y N P	Night Sweats?	Y N P
Temperature Change?	Y N P	Change in a mole?	Y N P

Head/Neck

Headaches?	Y N P	Head Injury?	Y N P
Migraines?	Y N P	Jaw/TMJ problems?	Y N P
Goiter?	Y N P	Swollen Glands?	Y N P

Eyes

Glasses/Contacts?	Y N P	Double/blurred vision?	Y N P
Eye pain?	Y N P	Spots in vision?	Y N P
Tearing or dryness?	Y N P	Itching/redness? Discharge?	Y N P
Glaucoma?	Y N P	Sensitive to the sun?	Y N P

Ear/Nose/Throat

Impaired hearing?	Y N P	Ringing?	Y N P
Frequent earaches?	Y N P	Vertigo?	Y N P
Discharge from ears?	Y N P	Infections?	Y N P
Sinus problems? Stuffiness?	Y N P	Nose bleeds?	Y N P
Frequent sore throats?	Y N P	Seasonal allergies?	Y N P
Teeth grinding?	Y N P	Loss of smell or taste?	Y N P
Gum problems?	Y N P	Frequent canker sores?	Y N P
Amalgam fillings	Y N P	Hoarseness?	Y N P

Immune

Chronically swollen glands?	Y N P	Chronic infections?	Y N P
Frequent colds/flu?	Y N P	Slow wound healing?	Y N P

Respiratory

Lingering cough?	Y N P	Tuberculosis?	Y N P
Spitting up blood?	Y N P	Asthma?	Y N P
Spitting up anything else?	Y N P	Wheezing	Y N P
Pneumonia?	Y N P	Bronchitis?	Y N P
Emphysema?	Y N P	Shortness of breath?	Y N P

Gastrointestinal

Trouble swallowing?	Y N P	Change in thirst?	Y N P
Nausea?	Y N P	Change in appetite?	Y N P
Vomiting?	Y N P	Heartburn? / Indigestion?	Y N P
Vomiting blood?	Y N P	Constipation?	Y N P
Blood in stool?	Y N P	Diarrhea?	Y N P
Abdominal pain or cramps?	Y N P	Worms/Parasites?	Y N P
Belching or passing gas?	Y N P	Gall bladder disease/stones?	Y N P
Black tarry stools?	Y N P	Ulcer?	Y N P
Jaundice (i.e., yellow skin)?	Y N P	Hemorrhoids/fissures?	Y N P
Liver disease?	Y N P	Hernia?	Y N P
Bowel movements - how often		Change in bowel movements?	Y N P

Cardiovascular

High blood pressure?	Y N P	Angina?	Y N P
Low blood pressure?	Y N P	Murmurs?	Y N P
Fainting?	Y N P	Blood clots?	Y N P
Past ECG? Or Echocardiogram?	Y N P	Palpitations/Fluttering?	Y N P
Rheumatic fever?	Y N P	Chest pain?	Y N P
Swelling in ankles?	Y N P		

Urinary

Pain on urination?	Y N P	Frequent infections?	Y N P
Increased frequency	Y N P	Inability to hold urine?	Y N P
Urination at night?	Y N P	Kidney stones?	Y N P
Urgency or hesitation?	Y N P	Blood in urine?	Y N P

Musculoskeletal

Joint pain or stiffness?	Y N P	Weakness?	Y N P
Broken Bones?	Y N P	Sciatica? Tail Bone?	Y N P
Muscle spasms or cramps?	Y N P	Backache?	Y N P
Joint swelling?	Y N P	Neck pain/stiffness?	Y N P

Mental/Emotional

Treated for emotional issues?	Y N P	Memory problems?	Y N P
Mood swings?	Y N P	Anxiety or nervousness?	Y N P
Poor concentration?	Y N P	Depression?	Y N P
Tension and/or stress?	Y N P	Considered/attempted suicide?	Y N P
Phobias?	Y N P	Seasonal depression?	Y N P

Male Reproductive

Hernias?	Y N P	Prostate enlargement or disease?	Y N P
Testicular pain or masses?	Y N P	Discharge or sores?	Y N P
Are you sexually active?	Y N P	Chlamydia? / Gonorrhea?	Y N P
Impotence?	Y N P	Herpes? / Syphilis?	Y N P
Premature ejaculation?	Y N P	Genital warts?	Y N P
Do you use birth control? What type?	Y N P		

Female Reproductive

Age at menses?		Difficulty conceiving?	Y N P
Age at last menses? (Menopausal)		Cervical dysplasia?	Y N P
Typical duration of bleed?	days	Pain during intercourse?	Y N P
Typical length of cycle?	days	Number of pregnancies?	
Are cycles regular?	Y N P	Number of live births?	Y N P
PMS? Symptoms?	Y N P	Number of miscarriages?	Y N P
Painful menses?	Y N P	Number of abortions?	Y N P
Heavy or excessive flow?	Y N P	Menopausal symptoms?	Y N P
Bleeding between periods?	Y N P	Chlamydia? / Gonorrhea?	Y N P
Clotting during menses?	Y N P	Herpes? / Syphilis?	Y N P
Are you sexually active? - Type of birth control?	Y N P	Genital warts?	Y N P
Date of last PAP?	Y N P	Unusual vaginal discharge?	Y N P
Abnormal PAP?	Y N P	Do you do breast self-exams?	Y N P
Endometriosis?	Y N P	Breast pain or tenderness?	Y N P
Ovarian cysts?	Y N P	Breast lumps?	Y N P

Have you had a mammogram?	Y N P	Nipple discharge?	Y N P

Endocrine

Fatigue?	Y N P	Heat or cold intolerance?	Y N P
Excessive thirst?	Y N P	Hypoglycemic?	Y N P
Excessive hunger?	Y N P	Excessive sweating?	Y N P
Excessive urination?	Y N P	Hormone Therapy?	Y N P

Blood / Peripheral Vascular

Easy bleeding or bruising?	Y N P	Anemia?	Y N P
Deep leg pain?	Y N P	Cold hands/feet/other?	Y N P
Varicose veins?	Y N P	Extremity swelling?	Y N P
Extremity numbness?	Y N P	Extremity ulcers?	Y N P

Neurologic

Seizures/convulsions?	Y N P	Numbness of tingling?	Y N P
Muscle weakness?	Y N P	Speech problems?	Y N P
Vertigo?	Y N P	Loss of balance?	Y N P
Paralysis?	Y N P	Involuntary movement?	Y N P

Is there anything else that you would like to add or comment on?

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Thank you for your time and effort.

This information will assist in providing you with quality naturopathic health care.