Camille Nghiem-Phu, BSc, ND Date: _____

NATUROPATHIC INTAKE FORM

Last name:_____ First name, initial: _____
Address: _____
City: _____ Province: _____ Postal Code: _____-____
Telephone: (____) _____-_____ Date of birth: _____/_____/_____Sex: M F
Business: (_____) _____-_____ Email address _____
Height: _____ Weight: _____

Emergency contact: _____ Relationship: _____
Emergency contact phone: (_____) _____-_____

Name of present MD: _____ Phone (___) _____-_____
Address of present MD: _____

What are your health concerns, in order of importance to you:
1. _____
2. _____
3. _____
4. _____
5. _____

If you are female, are you currently pregnant? Yes No

Medical Health of Patient:
Please check item(s) which **apply today or did in the past**:

- □ Asthma
- □ Diabetes
- □ Arthritis
- □ Cancer _____
- □ Liver Disease
- □ Heartburn
- □ Constipation
- □ Diarrhea
- □ Allergies
- □ High Cholesterol
- □ Chest Pain
- □ Headaches
- □ Anxiety
- □ Depression
- □ Thrush (fungal infection in the mouth from a Candida infection)

Past Childhood Illnesses:

- □ asthma
- □ eczema
- □ herpes
- □ meningitis
- □ pinworms
- □ ringworm
- □ chicken pox
- □ tuberculosis
- □ impetigo
- □ mononucleosis
- □ pneumonia
- □ roseola
- □ croup
- □ whooping cough
- □ lyme disease
- □ mumps
- □ poison ivy/oak
- □ rheumatic fever
- □ ear infection
- □ rubella (german measles)
- □ measles
- □ epilepsy/convulsions
- □ poliomyelitis
- □ tetanus

Vaccinations:

□ Hepatitis A □ "Flu" □ Polio
□ Hepatitis B □ DTP (diptheria, tetanus, pertussis) □ Smallpox
□ HiB (also called HbCV) □ IPV (injected polio vaccine)
□ OPV (oral polio vaccine) □ MMR (measles, mumps, rubella)
□ varivax (chicken pox) □ Tetanus "booster"; when? _____

Any reactions to the vaccines, and if so, what kind? _____

_____

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

Current Medications and Nutritional Supplements:

Any antibiotics? Y / N total number of courses of antibiotics: _____
1- Medication: _____ For: _____
Length of time on drug: _____
Reactions to drug? _____
2- Medication: _____ For: _____
Length of time on drug: _____
Reactions to drug? _____
3- Medication: _____ For: _____
Length of time on drug: _____
Reactions to drug? _____
Supplements (vitamins, minerals, herbs, etc.):

_____

_____

Do you frequently use any of the following? (circle)
Aspirin Laxatives Antacids Diet pills Birth control/injections/implants
Alcohol – how much/day or week _____
Tobacco – form and amount/day _____
Caffeine – form and amount/day _____
Recreational drugs – what and how often _____

Past hospitalizations: _____

_____

Past surgeries: _____

_____

Past emergency room trips: _____

_____

Family Medical History:

Please indicate by noting **M** (mother), **F** (father), **S** (sibling), **PGM** (paternal grandmother), **MGM** (maternal grandmother), **PGF** (paternal grand father), **MGF** (maternal grandfather)

Allergy, asthma or eczema _____ Liver disease _____
Cancer _____ Arthritis _____
Diabetes or low blood sugar _____ Mental illness _____
Heart disease _____ Lung disease _____
High blood pressure/stroke _____ Kidney disease _____
Other: _____

Diet

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

_____
_____
_____

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

_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (and total quantity) _____

Environment and Behaviours:

Occupation _____
Hobbies _____

Do you have trouble sleeping or falling asleep? Y / N
Explain: _____

Do you own any pets? Y / N If yes, what? _____ How long? _____

Average number of hours of television or computer/week _____

Do you exercise? Y / N If yes, how many hours per week? _____

How old is the home? _____ How is it heated? _____
Any recent home renovations? _____
How long have you been in the present home? _____
Is it located near: □trees □powerlines □highways □industry
□other: _____

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

_____
_____

How is the emotional atmosphere at home?

_____
_____

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

_____
_____
_____

General Review of Systems:

Do you have any rashes, lumps, sores, itching, dry skin, change in hair or nails?
Y / N If yes: _____
_____

Have you ever been unconscious, had a convulsion, have recurring headaches or had a head injury?
Y / N If yes: _____
_____

Any problems with hearing, ringing in the ears, dizziness, ear infections, discharge?
Y / N If yes: _____
_____

Any problems with teeth, gums, tongue, sore throats or hoarseness?
Y / N If yes: _____
_____

Any problem with the eyes, including vision?
Y / N If yes: _____
_____

Have you ever had a cough, wheeze, or asthma?
Y / N If yes: _____
_____

Any recurring problem with vomiting, diarrhea, constipation or stomach pain?
Y / N If yes: _____
_____

Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance to the urine?
Y / N If yes: _____
_____

Do you complain of any extremity or lower back pain? Y / N
Have you noticed a limp, or unusual gait pattern?
Y / N If yes: _____
_____

Have you ever had blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tremors, or other involuntary movements?
Y / N If yes: _____

Do you have any thyroid trouble, excessive thirst or hunger, heat or cold intolerance, or diabetes?
Y / N If yes: _____
_____

Any allergies, eczema, hay fever, hives or drug reactions?
Y / N If yes: _____
_____

Do you have any intense fears, mood swings, or other sensitivities?
Y / N If yes: _____
_____

OTHER HEALTH CONCERNS & ADDITIONAL INFORMATION:

_____
_____
_____