DR. MARILYN TRAN
Naturopathic Doctor

Adult Intake Form

Date: _____

Patient Information

Name: _____
Address:_____
City, Province, Postal Code: _____
Age: ____ Date of Birth (YYYY/MM/DD): _____
Gender: _____ Sex at Birth (Circle): M / F
Home Telephone Number: _____
Cell Phone Number: _____
Work Phone Number: _____
May we leave messages relating to your visits? (Circle) Y / N
Which Phone Number? _____
E-mail: _____
How did you hear about me? _____

Emergency Contact:
Name: _____
Relation: _____
Phone Number: _____

Medical Doctor:
Name: _____
Address: _____
Phone Number: _____

Work:
Occupation: _____
Employer: _____
Insurance Carrier: _____

Health History

What are your main health concerns or treatment goals?
1)_____
2)_____
3)_____

Please list any current medications and/or supplements you may be taking:

_____
_____

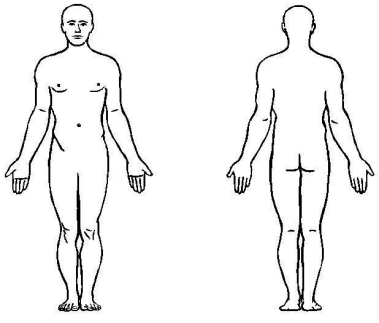
Please list any serious conditions, illness or injuries, and any hospitalizations or surgeries, including dates:

_____
_____

Please list any allergies (medicines, environmental, etc.):

_____
_____

Pain – Please circle areas that are painful / tense:



Please check any conditions **you** currently have now or in the past:

- ☐ Allergies / Sensitivities: _____
- ☐ Anemia
- ☐ Arthritis
- ☐ Bleeding Disorder
- ☐ Cancer
- ☐ Diabetes
- ☐ Cardiovascular Disease: _____
- ☐ Hepatitis
- ☐ HIV / AIDS
- ☐ Mental Health Condition (e.g., Depression, Anxiety, etc.):
  _____
- ☐ Other: _____

Please check any conditions that have occurred in **family members**:

- ☐ Arthritis
- ☐ Autoimmune Disease (e.g., Lupus, Inflammatory Bowel Disease, etc.): _____
- ☐ Cardiovascular Disease
- ☐ Cancer
- ☐ Diabetes
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Mental Health Condition (e.g., Depression, Anxiety, etc.):
  _____
- ☐ Other: _____

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Please check any general symptoms you have experienced in the **past year**:

- ☐ Notable weight loss or gain
- ☐ Head Injury
- ☐ Headaches / Migraines
- ☐ Sexual Difficulties
- ☐ Irritability
- ☐ Feelings of Sadness or Depression
- ☐ Nervousness or anxiety
- ☐ Excessive Fear
- ☐ Excessive Anger
- ☐ Excessive Worry
- ☐ Feeling Overwhelmed
- ☐ Easily Startled
- ☐ Notable Hair Loss
- ☐ Fatigue / Weakness
- ☐ Difficulty Focusing, Poor Memory or Concentration
- ☐ Feeling cold
- ☐ Night Sweats or Excessive Sweating

Rate: (Low) 0-1-2-3-4-5-6-7-8-9-10 (High)

Energy level: _____ **Overall health:** _____

Commitment to Treatment: _____

Biggest Stressors: _____

What do you love to do? _____

Review of Systems

Please check any symptoms you have experienced at any time in your history:

Musculoskeletal
- ☐ Pain / Weakness of Muscles
- ☐ Tremors or Cramps
- ☐ Swollen Joints
- ☐ Joint Stiffness
- ☐ Fracture / Dislocation
- ☐ Herniated Discs
- ☐ Bulging Disc
- ☐ Painful Tailbone
- ☐ Strains / Sprains
- ☐ Back pain

Cardiovascular
- ☐ Chest Pain
- ☐ Irregular Heart Beats
- ☐ Murmurs
- ☐ Palpitations
- ☐ Poor Circulation
- ☐ Swelling of Hands, Ankles, Feet

Eyes, Ears, Nose, & Throat
- ☐ Headaches
- ☐ Blurred Vision / Visual Changes
- ☐ Eye Pain
- ☐ Loss of Hearing
- ☐ Earaches
- ☐ Ringing in the Ears
- ☐ Allergies
- ☐ Sinus Problems
- ☐ Sore Throat
- ☐ Long Recovery Following Infections
- ☐ Dental grinding or clenching teeth at night
- ☐ Jaw Pain / Discomfort

Briefly describe your dental history (roots canals, extractions, etc.):

_____

Immune
- ☐ Frequent Colds, Flus, or Infections

Skin
- ☐ Poor Wound Healing
- ☐ Easy or Unexplained Bruising
- ☐ Rashes / Eczema
- ☐ Psoriasis
- ☐ Itching
- ☐ Dryness
- ☐ Frequent / Recurring Skin Infections
- ☐ Acne
- ☐ Change in mole
- ☐ Warts (hands/genital)

Digestion
- ☐ Change in Appetite
- ☐ Change in Thirst
- ☐ Gas / Bloating
- ☐ Abdominal Pain / Cramping
- ☐ Heartburn / Acid Reflux
- ☐ Belching
- ☐ Difficulty Swallowing
- ☐ Nausea / Vomiting
- ☐ Diarrhea
- ☐ Liver problems
- ☐ Gallbladder problems
- ☐ Blood or Mucus in the Stool
- ☐ Constipation
- ☐ Irregular Bowel Movements
- ☐ Pain / Itching of the Anus
- ☐ Worms

Nervous System
- ☐ Numbness / Tingling
- ☐ Seizures

Respiratory
- ☐ Shortness of breath
- ☐ Asthma / Bronchitis
- ☐ Chronic Cough
- ☐ Spitting up blood
- ☐ Spitting up phlegm

Sleep
- ☐ Difficulties Falling Asleep
- ☐ Difficulties Staying Asleep
- ☐ Waking Un-refreshed
- ☐ Sleep apnea
- ☐ Snoring
- ☐ Excessive Dreaming or Nightmares

Genitourinary
- ☐ Blood or Mucus in Urine
- ☐ Pain on Urination
- ☐ Frequent Urination
- ☐ Urgency
- ☐ Kidney Stones
- ☐ Bladder Infection
- ☐ Lowered Sex Drive
- ☐ History of Sexually Transmitted Infections

How many times do you wake up to go to the bathroom at night?

_____

Men's Health
- ☐ Erectile Difficulties
- ☐ Prostate Difficulties
- ☐ Difficulty Urinating Completely
- ☐ Discharge / Sores
- ☐ Testicular Masses
- ☐ Testicular Pain

Women's Health
- ☐ Menopausal Symptoms
- ☐ Bleeding between Periods
- ☐ Clots in Menstrual blood
- ☐ Heavy or Excessive Menstrual Flow
- ☐ Scanty or Light Menstrual Flow
- ☐ Irregular Cycles
- ☐ Painful Menstruation
- ☐ Low back pain just before or during menstruation
- ☐ Headaches / migraines just before or during menstruation
- ☐ Painful intercourse
- ☐ Vaginal discharge

Any other symptom during menstruation:

_____

_____

_____

- ☐ Lumps in the breast

Do you do self-breast exams? (Circle) Y / N

- ☐ Difficulties Becoming Pregnant
- ☐ Difficulty Maintaining a Pregnancy / History of Miscarriages

Are you currently pregnant? (Circle) Y / N

Date of first menses:

_____

Number of pregnancies: _____

Number of children: _____

Date of last PAP: _____

Environmental and Social Factors

1. Do you exercise regularly? (Circle): Y / N What do you do for exercise? How much? How often?

_____

_____

_____

2. How many people live in your home (e.g., spouse, children, roommates, etc.)? Please specify.

_____

3. Are you exposed to significant tobacco smoke (e.g., work, home, etc.)? (Circle): Y / N
4. Are you frequently exposed to animals (e.g., work, pets, etc.)? (Circle): Y / N
5. How is your home heated? _____
6. Are you regularly exposed to toxins or other hazards (e.g., home, work, hobbies, etc.)? Please describe.

_____

_____

7. Do you have a strong emotional support system (e.g., family, friends, colleagues, etc.)? (Circle): Y / N
8. How would you describe the emotional climate of your home?

_____

_____

9. How stressful is your work? How stressful are other aspects of your life? How well do you handle these stresses?

_____

_____

_____

10. What behaviours of lifestyle habits do you currently engage in that you believe support your health?

_____

_____

11. What behaviours or lifestyle habits do you currently engage in that you believe are NOT supportive of your health?

_____

_____

12. What potential obstacles do you foresee in addressing the lifestyle factors that are undermining your health and would decrease compliance in adhering to your treatment plan?

_____

_____

13. What expectations do you have from your FIRST VISIT?

_____

_____

14. What LONG TERM expectations do you have from working with me?

_____

_____

15. Is there anything else you feel is important that has not been covered?

_____

_____