Head to Toe
Chiropractic and Wellness Centre

Naturopathic Consultation Intake Form

Date: _____

Name: _____ Age: _____ Date of Birth: _____ Gender: M F

Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Work/Cell Phone: _____

May we leave messages related to your visit? Y N Preference: _____

Email Address: _____

Other Health Care Providers (name and phone numbers):

1. _____ Phone:_____
2. _____ Phone: _____

Permission to contact the above health care practitioners: Y N

Emergency Contact Name: _____

Relationship: _____ Phone_____

How you heard about the naturopathic services at this office: _____

Referred by: _____

Current Health Conditions

What are your health concerns? Please list in order of importance to you:

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

Has anything changed recently or become worse? _____

Medical History

Please indicate any serious conditions, illnesses, injuries and hospitalizations, with approximate dates.

_____

_____

Do you have any allergies? (drugs, environmental, food, etc.)?

_____

_____

Check (✓) any of the following that you currently use and indicate how often you use them or how long you have been using them:

❑ Laxatives ❑ Birth Control Pills ❑ Sleeping pills ❑ Antacids

❑ Cortisone ❑ Pain relievers ❑ Aspirin ❑ Anti-depressants

Please list all current prescription medications:

Name (Brand)	Daily Dose

Please list all current supplements or over the counter medications:

Name (Brand)	Daily Dose

Date of last physical exam with blood work: _____

Any concerns with last physical exam or blood work? _____

Personal Health Habits

Height: _____ Current weight: _____ Ideal weight: _____

Smoker: Y N Smoked _____ years Amount/day: _____ Year stopped: _____

Alcohol use: Y N Type: _____Frequency:_____

Recreational drug use: Y N Type: _____ Frequency: _____

Coffee: Y N _____ cups/day Tea: Y N _____cups/day

Water Intake: _____cups/day Tap or purified water: _____

Are there any food groups that you avoid? Y N _____

Are there any food groups that you eat a lot of? Y N _____

Do you eat dairy products? Y N _____

On a scale of 1 to 10, with 10 being the highest, please rate your average stress level: _____

On a scale of 1 to 10, with 10 being the highest, please rate your energy level: _____

How many hours of sleep do you get a night? _____ Do you wake up feeling rested? Y N

Exercise? Y N Type: _____ Duration: _____ Frequency: _____

Women Only

Are you currently pregnant? ❑ Yes ❑ No ❑ Maybe

Are you planning to get pregnant? ❑ Yes ❑ No ❑ Maybe

Type of birth control used: _____

If birth control pills used, how many years _____

Diet

Please list any food allergies/intolerances

_____

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

_____

Personal Health History

Did you have any serious childhood diseases? _____

Have you ever had parasites that you are aware of? _____

Do you travel regularly and if so, where? _____

How many times each year do you get a cold or flu? _____

How many days are you sick with it? _____

Have you had a trauma or an illness that you feel you have never recovered from?

_____

Family Medical History

Please indicate if a close relative (parent, child, sibling or grandparent) has had any of the following:

	Who?		Who?
Allergies		Depression	
Arthritis		Other Mental Illness	
Asthma		Drug Abuse/Alcoholism	
Epilepsy		Bleeding Problems	
Heart Disease		Multiple Sclerosis	
High Blood Pressure		Kidney Disease	
Stroke		Tuberculosis	
Cancer		Thyroid Problems	
Diabetes		Other	

Environment

Occupation: _____

Are you regularly exposed to toxins or other hazards (home, work, hobbies)? Please describe:

_____

Are you frequently exposed to animals (work, pets, etc.)? _____

Context of Care

What are your treatment goals and expectations? _____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____

_____

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

_____

_____