Cure Integrative Clinic Forms

Adult Intake Form

1- Patient information

Name:_____Referred by_____

(First) (Last) (Initial)

Date of Birth: year/month/day _____Age_____

Gender:_____

Place of birth: _City_____Country_____

Marital status: _____

Address:_____

Postal Code: _____

Phone: _____

(Home) (Cell) (Work)

Employment status, circle one:

Full Time/Part-time/Unemployed/Retired/Student

Occupation:_____Employer_____

2- Emergency contact information:

Name:_____

Phone:_____

Address: _____

Relationship to patient:

_____

3- Insurance information:

Health insurance provider: _____

Policy Subscribers name: _____

Policy Subscriber's Date of Birth: _____

Patient's relationship to subscriber: _____

Health Insurance policy number _____

4- Circle of care:

Family physician/referring physician: _____

Phone: _____Fax:_____

How did you know about our clinic? _____

When was your last physical exam? _____
(Month) (Year)

Have you ever seen a naturopathic doctor before? Yes / No
List your health care providers (Specialist physician, Naturopathic doctor, Chiropractor, Registered massage therapist, Osteopath)

- _____
- _____
- _____
- _____
- _____

5- Medical history:

Health concerns:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

Do you have any of the following symptoms? Please answer yes or no.

Fever		Dizziness	
Headaches		Blurred vision	
Constipation		Hearing loss	
Diarrhea		Ringing in the ear	
Abdominal pain		Runny nose	
Heartburn		Sinus congestion	
Chest pain		Sore throat	
Palpitation		Cough	

Shortness of breath		Wheezes	
Fatigue		Anxiety	
Weakness		Depression	
Brain fog		Weight loss	
Weight gain		Pain with urination	
Blood in stool		Blood in urine	
Insomnia		Loss of appetite	
Rash		Difficult focusing	

Current Health status:

On a scale of 1-10, 10 being the best, how would you rate the following:

- Level of Energy: _____ Best in: Evening Morning Nights
- Level of Stress: _____
- Sleep quality: _____
- Mood: _____
- Your general health status: _____

Please list your health goals:

- _____
- _____
- _____
- _____

What is your present level of commitment toward addressing the underlying cause of your health conditions that may be related to lifestyle? Rate from Zero to 100% commitment:

_____

Please list all your medications:

Medication and dose	Started on	Reason	Prescribed by

Please list all your supplements:

Supplement	Dose	Brand	Started on	Recommended by

Have you ever had any of the following diagnostic tests?

Test	Yes or No
Electrocardiogram (EKG)	
X-ray	
CT scan	
MRI	
Endoscopy	
Ultrasound	
Any other diagnostic tests	

General health information:

Current Height:	
If you are over age 20, is your height the same as it was at age 20?	
Current Weight:	
Any weight changes in the last year?	
Maximum Weight	
Minimum Weight	

What do you feel is the most comfortable weight for you?	
When is the last time you were at this weight?	
What is your blood type (if known)?	
Have you ever received a blood transfusion?	
Have you had any colds, flus, and/or other acute illnesses in the past year?	
Do you have a contagious disease at this time?	
Is there any chance you are currently pregnant?	
Are you trying to become pregnant?	
Do you have any chronic health condition which you did not list under the Health Concerns section?	

6- Past medical history:

Please list all previous surgeries, major illness, or hospital admissions:

- _____
- _____
- _____

7- Allergies:

- Drug allergies: _____
- Environmental allergies: _____
- Food allergies: _____

8- Social information:

1. With whom do you live? List names, age, relationship:
_____
_____
_____

2. Do you have pets or farm animals?_____ If yes, where do they live? Indoors___Outdoors_____

3. Where do you live? ____Apartment _____House_____Other_____

4. How old is your house:_____Any renovations or new constructions?_____Any flooding_____Any mold?_____

5. Do you live near high voltage electric towers?____

Do you live near a golf course?_____

Do you live near a factory?_____

Do you live near a farm? _____

6. Have you traveled or lived outside Canada recently?_____ When? _____ Where? _____For how long?_____

7. Have you experienced any traumatic life event? Please, explain:

_____

8. Have you experienced a new major change in your life?

_____

9. Have you camped over the last 5 years?_____When? _____ Where?_____

10. How important is religion (or spirituality) for you and your family's life?

a. _____ not at all important

b. _____ somewhat important

c. _____ extremely important

11. Unfortunately, abuse and violence of all kinds, verbal, emotional, physical, and sexual are leading contributors to chronic stress. Knowing about your past experience would allow us to provide you with the optimum care.

Please do your best to answer the following questions:

- Did you feel safe growing up?_____
- Have you been in an abusive relationship? _____, if yes, is it past or current? _____
- Was alcoholism or substance abuse present in your childhood home, or is it present now in your relationships? _____
- Have you had any violent or otherwise traumatic life experiences, or have you witnessed any violence or abuse? _____

12. Do you drink alcohol? _____ What kind?_____How much per week? _____

13. Do you smoke? _____How many cigarettes per day? _____For how long?____

What age did you start?_____ Have you ever quit?_____ When?_____

14. Do you use recreational drugs? ____What kind?_____ Past use?

_____What kind?_____

15. If you moved to Canada, when was that? _____Where did you move from _____

9- Family history: Please check the applied health condition for each relative?

	Mother	Father	Grandparents	Sisters	Brothers
Age					
Heart disease					
Diabetes					
High blood pressure					
Asthma					
Cancer					
Stroke					
Heart attack					
Autoimmune					
Mental health					
Obesity					
Thyroid					

10- Wheel Of Balance

Wellness is a balance of many factors. Indicate your level of satisfaction in each of the following areas (1-10, 10 being the best):

Physical Health	
Mental Health	
Career	
Money	
Significant Other	
Personal Growth	
Physical Environment	
Family& Friends	
Fun & Recreation	

Medical Symptom Questionnaire

Rate each of the following symptoms based upon your typical health profile for the past 30 days
0 - Never or almost never have the symptom 1 - Occasionally have it, effect is not sever 2 - Occasionally have it, effect is severe 3 - Frequently have it, effect is not severe 4 - Frequently have it, effect is severe

HEAD	Headache	
	Faintness	
	Dizziness	
	Insomnia	
Total		
EYES	Watery or itchy eyes	
	Swollen, reddened or sticky eyelids	
	Bags or dark circles under eyes	
	Blurred or tunnel vision	
Total		
EARS	Itchy ears	
	Earaches, ear infections	
	Drainage from ear	
	Ringing in ears, hearing loss	
Total		
NOSE	Stuffy nose	
	Sinus problems	
	Hay fever	
	Sneezing attacks	
	Excessive mucus formation	
Total		
MOUTH/THROAT	Chronic coughing	
	Gagging, frequent need to clear throat	
	Sore throat, hoarseness, loss of voice	
	Swollen or discolored tongue, gums, lips	
	Canker sores	
Total		
Skin	Acne	
	Hives, rashes, dry skin	
	Hair loss	
	Flushing, hot flashes	
	Excessive sweating	
Total		
Heart	Irregular or skipped heartbeat	
	Rapid or pounding heartbeat	
	Chest pain	
Total		
Lungs	Chest congestion	
	Asthma, bronchitis	
	Shortness of breath	
	Difficulty breathing	
Total		
DIGESTIVE TRACT	Nausea, vomiting	

	Diarrhea	
	Constipation	
	Bloated feeling	
	Belching, passing gas	
	Heartburn	
	Intestinal/stomach pain	
Total		
JOINTS/MUSCLE	Pain or aches in joints	
	Arthritis	
	Stiffness or limitation of movement	
	Pain or aches in muscles	
	Feeling of weakness or tiredness	
Total		
WEIGHT	Binge eating/drinking	
	Craving certain foods	
	Excessive weight	
	Compulsive eating	
	Water retention	
	Underweight	
Total		
ENERGY/ACTIVITY	Fatigue, sluggishness	
	Apathy, lethargy	
	Hyperactivity	
	Restlessness	
Total		
MIND	Poor memory	
	Confusion, poor comprehension	
	Poor concentration	
	Poor physical coordination	
	Difficulty in making decisions	
	Stuttering or stammering	
	Slurred speech	
	Learning disabilities	
Total		
EMOTIONS	Mood swings	
	Anxiety, fear, nervousness	
	Anger, irritability, aggressiveness	
	Depression	
Total		
OTHER	Frequent illness	
	Frequent or urgent urination	
	Genital itch or discharge	
Total		
Grand total		