1281 Shoppers Row
Campbell River, BC V9W 2C7
Tel: (250) 287-7429
Fax: (250) 287-1133

NATUROPATHIC ADULT INTAKE

Naturopathic medical care requires a healthy relationship between provider and patient. Your responses to the following questions will significantly contribute to your doctor's understanding of you and your health history. ***Please complete in as much detail as you feel is relevant and to the degree that you are comfortable.*** *Thank you!*

PERSONAL INFORMATION:

Name: _____ Date of Birth: _____ Age: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone #: (H): _____ (Cell): _____ (W): _____

Okay to leave a message re: appointments? (Please circle) YES / NO Email: _____

Occupation: _____ Hours per week: _____ Employer: _____

Emergency contact: _____ Relation: _____ Phone: _____

MSP Care Card #: _____ Extended Coverage: YES / NO

How did you hear about our clinic? (Please check box)

- o Current patient of CR Chiropractic
- o Medical Doctor/Specialist (please provide name): _____
- o Other Health Care Provider (please provide name): _____
- o CR Chiropractic Staff
- o Social Media (Facebook, Twitter, etc)
- o Advertising
- o Website (campbellriverchiropractic.ca OR vitalrootswellness.ca)
- o Information Session
- o Other: _____

What expectations do you have of me as your physician?

_____

What expectations do you have from this first visit to our clinic?

_____

What is your **main reason** for seeking naturopathic care? If you have a specific health condition, please describe it in detail. (Eg. When was the first time you noticed your condition and describe any factors that you suspect may have played a role in its onset and continuation.)

_____

_____

_____

Please list **any other** health concerns (physical, emotional or mental) in order of importance:

_____

_____

_____

Current **general practitioner** - MD: _____ Phone: _____ Clinic: _____

List other **health professionals and their clinic name** you are seeing and include their area of practice (Eg. Massage).

Practitioner Name: _____ Practitioner Type: _____ Contact #: _____

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VITAL ROOTS Wellness

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Name: _____ *Date of Birth:* _____

How do you rate your overall health? POOR FAIR AVERAGE GOOD EXCELLENT
How do you rate your overall energy? POOR FAIR AVERAGE GOOD EXCELLENT

Current Weight: _____ Height: _____ Wt. 1 yr ago: _____ Max. adult Wt.: _____ Min. adult Wt: _____

MEDICATIONS:

Please list all current medications (prescription and over-the counter):

Medication	Dose/day	How long?
1.		
2.		
3.		
4.		

Approximately how many times have you taken antibiotics? _____
Have you had an adverse reaction to a medication? NO/YES List the Medication: _____

ALLERGIES:

List all (to medications, pollens, foods, animals etc.):

_____

_____

OVER THE COUNTER REMEDIES/SUPPLEMENTS:

List all remedies/supplements (herbal, vitamin/mineral, nutritional, homeopathic etc.) you are taking:

1.	5.
2.	6.
3.	7.
4.	8.

CHILDHOOD MEDICAL HISTORY:

Please **CIRCLE** if you have had any of the following childhood illnesses:

Asthma	Measles	Rheumatic fever
Chicken pox	Mumps	Diptheria
Scarlet fever	Mono (how long? _____)	Tuberculosis
Eczema	Polio	Whooping cough
Frequent ear infections/colds	Rubella (German measles)	Other: _____

IMMUNIZATIONS: (**CIRCLE** all that you have had)

DPT	HAEMOPHILUS	INFLUENZA B	HEPATITIS A	HEPATITIS B
MMR	TETANUS	CHICKEN POX	SMALLPOX	
POLIO	FLU SHOT	OTHER: _____		

Any adverse reactions to a vaccination? Briefly describe if applicable:

_____

_____

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Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations.

_____

_____

_____

FAMILY HISTORY:

Please indicate whether any of your family members have, or have had, the following:

Condition	Relative	Condition	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart condition	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	
Bleeding disorders		Infertility	
Glaucoma		Thyroid Conditions	

LIFESTYLE FACTORS

Any current dietary restrictions? (vegan, vegetarian, etc.) _____

How much water do you drink in a day? _____

On average, how many hours of sleep do you get each night? _____ Good Quality? Y/N

Do you exercise? Y / N What type(s) of exercise and what frequency? _____

_____

What do you enjoy for recreation and relaxation? _____

Do you have a religious or spiritual practice you would like us to know about?

_____

Do you currently consume any of the following? (Indicate how often, how much and for how long)

Alcohol: _____ Tobacco: _____

Coffee: _____ Soft drinks: _____

Black tea: _____ Marijuana: _____

Laxatives: _____ Other: _____

Are you frequently exposed to animals? Y / N Type: _____

Exposed to toxins or hazards at home? Y / N List: _____

Exposed to toxins or hazards at work? Y / N List: _____

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Name: _____ *Date of Birth:* _____

Relationship status: _____

Number of children + ages: 1) _____ 2) _____3) _____ 4) _____ 5) _____

What is the emotional climate of your home?

_____

_____

Rate your current stress level (**CIRCLE**): LOW AVERAGE HIGH UNBEARABLE

Which factors most contribute to your stress? (**CIRCLE**)

HEALTH WORK MONEY FAMILY RELATIONSHIP OTHER: _____

MALE REPRODUCTION

Do you have regular annual health screening tests? (blood work, prostate examination) Y / N

Date of last prostate examination? (month/yr) _____ / _____

Are you sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Any difficulty with urination? Y / N How often do you urinate at night? _____

Have you had any of the following? (**CIRCLE**)

TESTICULAR PAIN HERNIA STIs DISCHARGE SKIN LESIONS

Do you have any sexual problems or concerns? Y / N

If yes, please explain: _____

FEMALE REPRODUCTION

Are you currently pregnant? Y / N

Do you get regular PAP smears? Y / N Date of last PAP? (month/year) _____ / _____

Have you ever had an abnormal PAP? Y / N What was the outcome? _____

Age of first period? _____ Is your period regular? Y / N

Length of monthly cycle (eg 28,32): _____days Average # days of period or flow (3,5,7): _____

Do you experience PMS? Y / N Do you have spotting/bleeding between periods? Y / N

Please circle relevant PMS symptoms:

BLOATING BREAST TENDERNESS IRRITABILITY DEPRESSION

HEADACHES MOOD SWINGS FOOD CRAVINGS OTHER: _____

Are you menopausal? Y / N If yes, age of last period: _____

Are you sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception: _____

Have you ever had a sexually transmitted infection? Y / N

Number of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Have you ever had any of the following concerning your **breasts**? (**CIRCLE**)

PAIN LUMPS INFECTIONS CYSTS NIPPLE DISCHARGE

Do you experience vaginal infections? NEVER RARELY FREQUENTLY

Do you experience bladder infections? NEVER RARELY FREQUENTLY

Do you have any sexual problems or concerns? Y / N If yes, please explain: _____

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REVIEW OF SYSTEMS

Please **CIRCLE** if you are **currently** experiencing any of the following symptoms OR if you have experienced any of these symptoms before write a **"P"** for **Past**.

GENERAL SYMPTOMS:	**EARS/EYES/NOSE/THROAT**	**CARDIOVASCULAR:**
Headache	Dental decay	Low Blood Pressure
Head injury	Gum disorder	High Blood Pressure
Fever	Enlarged thyroid	Previous Stroke
Chills	Tonsillitis	Hardening Arteries
Sweats	Sore Throat	Swelling of Ankles
Dizziness	Hoarseness	Poor Circulation
Fainting	Enlarged Glands	Paralytic Stroke
Loss of Sleep	Glaucoma	Irregular Heart Beat
Fatigue	Failing vision	Shortness of Breath
Nervousness/Anxiety	Cataracts	Chest Pain
Loss of Weight	Eye Pain	
Numbness/pain (extremeties)	Ear discharge	**GASTROINTESTINAL:**
Allergies	Deafness	Bloating
Convulsions	Hay Fever	Excessive thirst
Depression	Mercury dental fillings	Excessive hunger
	Ear ache	Reflux
SKIN:	Nasal Discharge	Eating Disorder
Change in mole(s)	Nose bleeds	Belching
Hives / allergic reactions	Nasal obstruction	Gas (flatulence)
Acne / skin eruptions	Sinus Infection	Nausea
Itching (ears, skin, rectum)		Vomiting
Bruising easily	**MUSCLE & JOINT**	Vomiting of blood
Dryness	Fracture/dislocation	Abdominal Cramps
Boils	Stiff neck	Constipation
Varicose veins	Back pain	Diarrhea
Sensitive skin	Muscle weakness	Hemorrhoids
	Swollen joints	Liver problems
KIDNEYS/REPRODUCTIVE	Painful tailbone	Jaundice
Prostate inflammation	Foot problems	Gallbladder issues
Genital lesions	Pain in shoulders	Irritable Bowel syndrome
Inability to control urine	Hernia	Crohn's Disease
Frequent urination	Spinal curvature	Ulcerative Colitis
Painful urination	Poor posture	
Blood in urine	Arthritis	RESPIRATORY
Pus in urine		Asthma
Kidney infection		Difficulty breathing
Kidney stones		Chronic cough
Erectile dysfunction		Spitting up phlegm
Infertility		Spitting up blood

Thank you for taking the time to fill this out completely.