136 Jenkins Road RR4, Scotland ON N0E 1R0
Phone: (519) 484 9999 Fax: (519) 484 9995
www.woodsideclinic.com

Naturopathic Medicine - Traditional Chinese Medicine - Acupuncture

INTAKE FORM – FEMALE

*(Please **circle** answer where ever there is a multiple question.)* Date:___________________________

Name: ____Age: _________Date Of Birth: __________________________________

Address: ____City ______________________________

Postal Code________________________________ Email Address____

Home Phone ( )___________________________________ Work Phone: ( )____________________________________

Marital Status: S M D W Sep Number of Children:_________ Referred by:___________________________________

Occupation : ______________________________________ Employer:____

Employment Status: Full-Time Part-Time School Retired Unemployed Self-Employed Other

Living Situation: Alone Spouse Partner Friend(s) Parent(s)

Name and ages of those living with you____

Pets: ____

Name of Partner/Spouse/Parent:: _________________________________ Occupation: ________________________

In case of emergency notify: ____________________________________ Phone No: _________________________

Religious/Spiritual Preferences: ____

Educational background: ____

How did you hear about the Woodside Clinic? ____

Please **list** the **major complaints in order of importance for you:**

	Complaint	Since	Cause
1.			
2.			

MEDICAL STATUS

General Health: Excellent Good Fair Poor

List any allergies? ____

What **medications** are you currently taking?

____ ____
____ ____
____ ____

What was the date of your last full medical examination? The date(s) of any blood test(s) you have had done:

List any **vitamins, supplements, homeopathic** or **herbal medications** you are taking:

____ ____
____ ____
____ ____
____ ____

What other treatments are you currently following?

____
____
____

Have you ever had your cholesterol level checked? ________ Date(s) ____________ Result(s) ______________________
Have you ever had a mammogram? ________ Date(s) ____________ Result(s) ______________________
Do you do self-breast exams? ________

Health History (Please **circle** if you **Had or Have** any of the following):

Abscesses	Chicken pox	Fungal infections	Kidney disease	Rheumatic fever	Syphilis
Alcoholism	Chronic fatigue	Gallstones	Leukemia	Rubella	Tonsillitis
Allergies	Circulation	Glaucoma	Liver disease	Scarlet fever	Tuberculosis
Amnesia	Cold sores	Goiter	Migraines	Senility	Typhoid fever
Anemia	Colitis	Gonorrhea	Miscarriage	Serious injury	Venereal warts
Anorexia	Colon disease	Gout	Mononucleosis	Sexual abuse	Warts
Arthritis	Compulsive eating	Hay fever	Mumps	Sinusitis	Whooping cough
Asthma	Depression	Heart disease	Parasites/worms	Skin disease	Yellow fever
Autoimmune	Diabetes	Hepatitis	Peritonitis	Strept throat	
Bleeding disorders	Eczema	Herpes genitalia	Pelvic inflammation	Stroke	Thalassemia
Cancer	Emphysema	Hypertension	Pleurisy	Sunstroke	Sickle cell anemia
Candida (Yeast)	Epilepsy	Hypoglycemia	Pneumonia		Fava bean intolerance – G6PD deficiency

Other Past Medical Conditions

High Blood Pressure		Stroke	Varicose Veins	Phlebitis	Clotting defects	Bleeding tendencies
Blood transfusion	Diabetes	Kidney trouble	Rheumatic fever	Jaundice/Hepatitis		Epilepsy
Arthritis	Colitis	Asthma	Chronic Fatigue Syndrome/Epstein Barr			

Childhood diseases: German Measles Chicken Pox Other: ________________________

Heart Trouble: ______________ Fractures: ____________ Cancer: ______________ Eating Disorder: ________________

Other major conditions? ____
Never well since an illness or infection (what?)____
Had a chronic/reoccurring infection or problem (what?)______________________________________

HABITS

Dietary preferences/restrictions: ____________________

Is your food organic? Y N local food? __________ what % of food is organic/local? __________

Sample of day's menu:
Breakfast: ____________________
Lunch: ____________________
Dinner: ____________________

Do you use salt and if so, how much? __________ What brand of salt do you use? __________

Routine physical exercise?
Type of exercise: ____________________

For how many minuets? __________ How often? __________
Tobacco use (how much): __________ Previously? ______ How much? ______ How long?______
Alcohol use (how much): __________ How often? __________
Caffeine use (how much): __________ Mood altering substance use (e.g. marijuana, cocaine) past & present? ______

STRESSES

Stresses (family, work, self, etc.):
____
____
____

Have you had any **Hospitalization, Surgeries,** etc. List what type they were, when they occurred and if there were any complications.

Diagnosis/Operation	Hospitalization/Date	Doctor	Complications

DENTAL HISTORY

Name of Dentist: ____________________

Address:____________________

Phone Number ____________________

Date of last dental check-up: __________ For what? ____________________

Do you have: Root Canals ______ how many? ______ date(s) ____________________

Silver Fillings ______ how many? ______ date(s) ____________________

Gum Disease ____________________

What kind of mouthwash do you use? ____________________

What kind of toothpaste do you use? ____________________

YOUR HOME

WATER SOURCE:
City Water? Y N what city?______________________________ Well Water Y N Date well water last tested ____________________________
Purifiers Y N Brand Name ____ Purifier on drinking water Y N Purifier on Shower Head Y N
any lead pipes? Y N

AIR FILTRATION
Air filtration in the home? Manufacture & Type _________________________________ Date installed in home __________________
Do you live near a factory? Name ____

New home (last 2-3 years) or Older Home Building Materials____

Upholstery – any new materials in the home eg carpeting, pets, paint, wallpaper ____

Plasma TV Y N

Microwave use Y N how often _____________ do you use plastic wrap in the microwave Y N

Wifi Y N Laptop computer Y N if Yes – do you use on your lap Y N how many hours ________________________

Cell phone Y N how many minutes a day do you use it? _______________________________

List electronic equipment near sleeping area i.e. clock radio, TV, computer ____

Do you use an electric blanket Y N Do you use a mattress warmer Y N

LAUNDRY: name of detergent used ______________________________ do you use Fabric softener sheets Y N

PERSONAL HYGIENE AND ATTIRE

CLOTHING: organic natural cotton synthetic polyester silks

HYGIENE cleansing products ________________________________
Deodorant/Antiperspirants brand _________________________ Cologne brand ____________________________
Shampoo ___________________________ Hair care products ____
Do you color your hair Y N brand used ____

Do you use mosquito repellent? Y N Brand ____

VACCINATIONS

Childhood vaccinations? Y N
Any recent vaccinations? i.e. flu shot, travelling vaccines, HPV ________________________ date ________________________

Any adverse reactions? ____

TRAVEL

Time spent travelling to/from work ______________________________
Do you drive, car pool, bike, take train, walk, bus eg __________________________________
Do you work in the city or country ____
Do you travel in an airplane Y N how often? _______________________________

Any other exposure to toxic pollutants? ____

PREGNANCIES (including miscarriages and abortions)

Dates	How Far Along?	Sex	Weight	Problems?

GYNECOLOGICAL HISTORY

Date last period began: ____________ Date of last pelvic exam: ____________
Date prior period began? ____________ Date of last Pap smear: ____________
Was your last Pap smear normal? ____________ Age at first period: ____________
Did you ever have an abnormal Pap? ________ When: ________ Results: ____________
Treatment: ____________
Are you sexually active? ________ Do you have intercourse? ________ Do you practice safe sex? ________
Are you trying to get pregnant? ________ How long? ____________
Current birth control method: ____________ How long? ____________
Problems with current birth control method? ____________
Past birth control methods: ____________
Normally (not on pills), the number of days from the start of one period to the start of the next? ____________
Number days of flow: ________ Amount of bleeding: ________ Amount of cramps: ____________
Premenstrual symptoms: ____________ Starting when? ____________
Any current changes in your normal pattern? ____________
Any bleeding between periods? ________ When? ____________
Any unusual pelvic pain, pressure, or fullness? ________ When? ____________
Describe: ____________
Any unusual vaginal discharge or itching? ________ Describe: ____________
How long? ____________ Past treatment: ____________
Any sexual concerns to discuss? ____________
Any past history of tubal infection? ________ When? ____________
Any past history of sexually transmitted disease? ________ What & When: ____________
____
Any history of DES exposure (DES was a drug taken by mothers during pregnancy to prevent miscarriage)?
____
Other:
____

Any past history of tubal infection? ________ When? ____________
Any past history of sexually transmitted disease? ________ What & When: ____________
____
Any history of DES exposure (DES was a drug taken by mothers during pregnancy to prevent miscarriage)?
____
Other:
____

CURRENT/RECENT HEALTH CARE PROVIDER(S)

Name	Date(s)	Care Provided

Which of the following **ailments**, or any **other major ailments**, have affected your **relatives**? Please **circle:**

Alcoholism	Asthma	Diabetes	Gout	Insanity	Skin disease
Allergies	Cancer	Epilepsy	Hay fever	Paralysis	Syphilis
Arthritis	Depression	Gonorrhea	Heart disease	Pneumonia	Tuberculosis

Other: ____________
____
____
____
____
____

Relatives	Age if alive	Age at death	Ailments
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Maternal Aunts/Uncles			
Paternal Grandmother			
Paternal Grandfather			
Paternal Aunts/Uncles			

REVIEW OF SYSTEMS

Circle any symptoms of **present** significance.

GENERAL PHYSICAL

Fever or Chills Hot Flashes Unusual Hair Growth Skin Eruptions
Weight Change

ABDOMOMEN

Bloating Heartburn/Indigestion Cramps or pain Nausea or Vomiting
Diarrhea Constipation Change in bowel habits Bloody or tarry stools
Hemorrhoids Flatulence

HEAD

Headaches Dizziness Visual defects Hearing defects
Sinus trouble Fainting spells

BLADDER

Frequent urination Painful urination Blood in urine
Inability to hold urine Inability to empty bladder Need to get up in the night to urinate

CHEST

Chest pain Shortness of breath Heart murmur Mitral valve prolapse
Palpitations Chronic cough Coughing up blood Wheezing

BREASTS

Lumps Bleeding Discharge Tenderness

COMMENTS OR OTHER CONCERNS:
____
____

What are your goals and/or expectations of visiting a Naturopathic Doctor?

____
____

What changes have been made to improve your quality of life?

____
____
____
____
____

Acupuncture

Have you had any acupuncture treatment before and if so, when and for what purpose? ____________________________
____
____

Do you have any fear of needles? ________________
Do you have any bleeding disorders and if so, what? ____
What other acupuncture practices have you attended? ____
____
____

Be advised that a cancellation fee of $40 applies to appointments missed without 24 hours' notice. (Weather permissible.)