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 – MALE (16 years of age or older)

*(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.			
3.			
4.			

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) __________________________

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

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

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?)________________________________

DIET & EXERCISE

Dietary preferences/restrictions: ____

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

Any exposure to Pesticide/ Insecticide/ Fungicide

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? ____

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 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

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.)