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INTAKE FORM – FEMALE

PLEASE NOTE: WE ARE A FRAGRANCE FREE BUILDING

*(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

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 | |
| Cancer | Emphysema | Hypertension | Pleurisy | Sunstroke | |
| Candida (Yeast) | Epilepsy | Hypoglycemia | Pneumonia | | |

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: _____

Sample of day's menu:

Breakfast: _____

Lunch: _____

Dinner: _____

Routine physical exercise?

Type of exercise: _____

For how many minutes? _____ 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 _____

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: _____

CURRENT/RECENT HEALTH CARE PROVIDER(S)

Name	Date(s)	Care Provided
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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?

**** Please be advised that a cancellation fee of \$40 applies to appointments missed without 24 hours notice. (Weather permissible.)***