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INTAKE FORM – MALE (16 years of age or older)

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.			
3.			
4.			

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) _____

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 | |
| Autoimmune | Diabetes | Hepatitis | Pelvic inflammation | Stroke | |
| Bleeding disorders | Eczema | Herpes genitalia | Pleurisy | Sunstroke | |
| 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?) _____

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 _____

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 | Gonorrhoea | 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

ABDOMEN

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?

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