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*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** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

MEDICAL STATUS

General Health: Excellent Good Fair Poor

List any allergies? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

What **medications** are you currently taking?

­­­­­­­­­­­­­­ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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**What other treatments are you currently following?**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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.): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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##### 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

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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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 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**: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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

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Acupuncture

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

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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.)***