DR. SCARLETT ARMSTRONG
naturopathic doctor

DATE ____________________

CONFIDENTIAL ADULT PATIENT INTAKE FORM

____ SEX _______ BIRTHDATE _____/_____/_____
First Name Middle Name Last Name D M Y

HOME ADDRESS ____
Street City/Province Postal Code

HOME PHONE _________________________ WORK ________________________ CELL _________________________

EMAIL ____ ❑ OK to receive clinic notices ❑ Email for private use only

OCCUPATION: ___________________________________ EMPLOYER: ____

EMERGENCY CONTACT: ____
Name Relationship Phone

REFERRED BY: _____________________________________ GUARDIAN (if child) ______________________________

CARECARD NUMBER: ______________________________ FAMILY M.D. _____________________________________

WHEN WAS YOUR LAST VISIT TO YOUR MD? ____

ARE YOU SEEING ANY MEDICAL SPECIALISTS? Y❑ N❑ IF YES, FOR WHAT PURPOSE? _______________________

PRACTITIONER(S) I'VE SEEN RELATED TO MY MAJOR CONCERN:

____

____

____

Name Type of Practitioner Treatment(s)

DO YOU HAVE ANY KNOWN CONTAGIOUS ILLNESSES AT THIS TIME? Y❑ N❑ IF YES, WHAT? __________________

DO YOU HAVE ANY KNOWN ALLERGIES/SENSITIVITIES? Y❑ N❑ IF YES, PLEASE LIST:

FOODS ____________________________________ DRUGS (e.g. Penicillin) ___________________________________

ENVIRONMENTAL OR CHEMICALS (pollen, perfume, sulfites, latex) ______________________________________

EXPOSURE TO TOXINS (glues, pesticides, dye, ink) ____

CURRENTLY ON A DIET OR AVOIDING CERTAIN FOODS? ____

____

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HEALTH HISTORY QUESTIONNAIRE

WHAT IS THE MAIN REASON FOR YOUR VISIT TODAY? ______________________________

WHAT ARE YOUR MOST IMPORTANT HEALTH CONCERNS? PLEASE LIST IN ORDER OF IMPORTANCE TO YOU:

1. ______________________________
2. ______________________________
3. ______________________________
4. ______________________________
5. ______________________________
6. ______________________________

PAST & PRESENT ILLNESSES (asthma, bronchitis, hepatitis, eczema, cancer, etc., including hospitalizations):

____

PAST ACCIDENTS/INJURIES/TRAUMAS (MVA, head injury, fractures, recurrent sprains, whiplash, sciatica, etc.):

____

____

IMAGING (Ultrasounds, X-rays, CT scans, MRIs; please note dates if possible): ______________________________

____

SCARS, SURGERIES (include tonsils, wisdom teeth, tattoos, stitches, mole removals): ______________________________

____

CHRONIC OR CURRENT PAIN (low back, headache, TMJ) ______________________________

MOTHER'S FAMILY HISTORY: ______________________________

FATHER'S FAMILY HISTORY: ______________________________

CURRENT PRESCRIPTIONS OR OVER THE COUNTER MEDICATIONS (include dose & brand name if known):

____

____

CURRENT REMEDIES (nutritional, herbal, vitamins, minerals, homoeopathic; dose & brand name if known):

____

____

PAST PRESCRIPTION MEDICATIONS AND/OR NATURAL HEALTH PRODUCTS:

____

____

HEIGHT __________ WEIGHT __________ WEIGHT 1year ago __________

WHEN DURING THE DAY IS YOUR ENERGY BEST? __________ WORST? __________

DO YOU SMOKE CIGARETTES? Y❑ N❑ In the past ❑ # pack(s)/day __________ # years? __________

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ALCOHOL USE ? Y❑ N❑ type ________________________ frequency ________________

COFFEE Y❑ N❑ cups/day ______ TEA Y❑ N❑ cups/day ______ WATER Y❑ N❑ cups/day ______

RECREATIONAL DRUG/MARIJUANA USE? Y❑ N❑ No answer❑ type ____________ frequency ______

OF DENTAL: EXTRACTIONS _________ ROOT CANALS _________ SILVER FILLINGS _________

PLEASE INDICATE WHICH VACCINATIONS YOU HAVE HAD:

___ DPT (diptheria, pertussis, tetanus) ___ Haemophilus influenza b (Hib) ___ Polio

___ MMR (measles, mumps, rubella) ___ Hepatitis A ___ Smallpox

___ Influenza (seasonal flu shot) ___ Hepatitis B ___ HPV

Date of last Tetanus booster ____

Other, please list ____

Please indicate if any caused adverse reactions: ______________________________

HOW MANY HOURS SLEEP DO YOU GET ON AVERAGE? ______ HOW MANY TIMES DO YOU WAKE UP? ____

IS YOUR SLEEP PATTERN MOSTLY CONSISTENT? Y❑ N❑ DO YOU WAKE UP RESTED? Y❑ N❑ SOMETIMES ❑

DO YOU HAVE DIFFICULTY FALLING ASLEEP? Y❑ N❑ STAYING ASLEEP? Y❑ N❑

WHAT DO YOU DO FOR EXERCISE (activity, intensity, frequency)? ___________________________

____

DO YOU HAVE ANY MAJOR STRESS FACTORS? On a scale of 1-10 (10 = highest) ___________________

____

DO YOU HAVE SUPPORTIVE RELATIONSHIPS? On a scale of 1-10 (10 = highest quality of support) _________

____

INTERESTS, HOBBIES, SPIRITUAL PRACTICE OR RELIGION ___________________________

____

WHAT HOPES OR EXPECTATIONS DO YOU HAVE OF BEING A PATIENT AT OUR CLINIC?

____

____

DO YOU HAVE ANY CONCERNS ABOUT NATUROPATHIC TREATMENT? (diet change, supplements, needles, appointments, homework, cost, etc.)

____

____

REVIEW OF SYSTEMS

NOW	PAST	ENDOCRINE
		Thyroid Problems
		Dysglycemia/hypoglycemia
		Diabetes
		Excess thirst or hunger

NOW	PAST	IMMUNE
		Recurrent infections
		Recurrent or chronic swollen glands, sore throat
		Poor wound healing

NOW	PAST	CARDIOVASCULAR
		Murmurs
		Blood clots
		Ankle swelling
		Palpitations or rapid heart beat
		Cold hands/feet
		Varicose or spider veins
		Anemia
		Easy bruising and bleeding
		Other blood disorder
		Chest pains
		Pain over heart
		Blood clots
		Blood pressure problems

NOW	PAST	RESPIRATORY
		Difficulty breathing, short of breath
		Persistent cough
		Coughing phelgm
		Dry cough
		Wheezing
		Nasal discharge, post nasal drip

NOW	PAST	MENTAL/EMOTIONAL
		Depression or seasonal affective disorder
		Anxiety/panic attacks
		Inability to concentrate, focus, multi-task
		Mood swings
		Irritability
		Forgetful, confusion, memory loss

NOW	PAST	MUSCULO SKELETAL
		Low back pain
		Pain between shoulders
		Neck problems
		Arm problems
		Leg problems
		Swollen joints
		Painful joints
		Stiff joints
		Sore muscles
		Weak muscles
		Walking problems
		Ruptures, hernia
		Broken bones
		TMJ

NOW	PAST	GASTRO INTESTINAL
		Excessive burping
		Excessive bloating, gas, flatulance
		Reflux, heartburn, hiatal hernia
		Abdominal pain or cramping
		Ulcers
		Constipation
		Diarrhea
		Stools with blood or mucous
		Undigested food in stools
		Nausea, vomitting
		Liver problems
		Gall bladder problems
		Difficulty chewing or swallowing
		Cravings
		Poor appetite
		Weight trouble

NOW	PAST	GENITO URINARY
		Bladder trouble
		Painful urination
		Scanty urination, dribbling
		Excessive urination
		Discoloured or smelly urine

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NOW	PAST	EYES, EARS, NOSE AND THROAT
		Eye strain
		Eye inflammation, bloodshot
		Eye pain, light sensitivity
		Vision loss, change
		Ear pain
		Ear ringing, noise
		Ear discharge, excessive wax
		Hearing loss
		Recurrent nose bleeds
		Nose discharge, sniffling
		Sinus pressure, pain
		Loss of smell or taste
		Snoring or sleep apnea
		Hayfever
		Dental problems
		Gums sore, bleeding, excessive receding
		Sore mouth, cancres
		Recurrent sore throat, swollen glands

NOW	PAST	NERVOUS SYSTEM
		Poor balance, accident prone
		Muscles always tight
		Muscle twitching, jerking
		Numbess, tingling
		Complete loss of feeling
		Head injury, concussion
		Major chronic pain
		Headaches, migraine
		Dizziness, vertigo, fainting
		Convulsion, epilepsy
		Pinched nerve, sciatica
		Neuropathy

NOW	PAST	FEMALE SYSTEM
		Menstrual problems
		Menopausal symptoms
		Vaginal pain, discharge, bleeding
		Sore breasts, lumps

OTHER ________________________________

Please mark areas of symptoms on the figures

XXX pain   ///// tingling   \\\\\ numb   vvvv stiffness

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