DR. SCARLETT COOPER
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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a. 109 - 6758 188th Street, Surrey BC V4N 6K2

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? _____

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

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.)

_____

_____

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REVIEW OF SYSTEMS

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

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

		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

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

		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

		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

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

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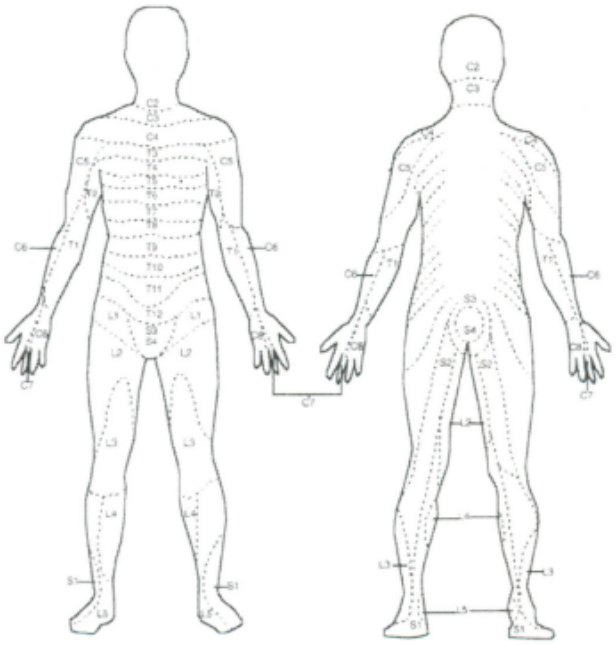
NOW	PAST	EYES, EARS, NOSE AND THROAT
		Eye strain
		Eye inflammation, bloodshot
		Eye pain, light sensitivity
		Vision loss, change
		Ear pain
		Ear ringing, noise
		Ear discharge, excessive wax
		Hearing loss
		Recurrent nose bleeds
		Nose discharge, sniffling
		Sinus pressure, pain
		Loss of smell 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

		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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