

ADULT INTAKE

First Name: \_\_\_\_\_ Last name: \_\_\_\_\_ Gender: M / F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal Code: \_\_\_\_\_

Please list only the numbers at which you would like to be contacted.

Phone (home): \_\_\_\_\_ Phone (work): \_\_\_\_\_

Email: \_\_\_\_\_ Cell phone: \_\_\_\_\_

Date of birth: \_\_\_\_\_ Age: \_\_\_\_\_ Occupation: \_\_\_\_\_

Marital Status: \_\_\_\_\_ Number in Household? \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_

Other health care providers:

Name: \_\_\_\_\_ Designation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Designation: \_\_\_\_\_ Phone: \_\_\_\_\_

Name: \_\_\_\_\_ Designation: \_\_\_\_\_ Phone: \_\_\_\_\_

How did you hear about Haessler Naturopathic?: \_\_\_\_\_

**THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE. INFORMATION CONTAINED HERE WILL NOT BE RELEASED TO ANY PERSON, EXCEPT FOLLOWING YOUR WRITTEN AUTHORIZATION. PLEASE COMPLETE THIS QUESTIONNAIRE AS THOROUGHLY AS POSSIBLE.**

What is the chief health concern that brings you to Haessler Naturopathic? \_\_\_\_\_

Please list any other health concerns (physical, emotional or mental) that you would like to address, how long you have had them, and who made the diagnoses:

- 1. \_\_\_\_\_
- 2. \_\_\_\_\_
- 3. \_\_\_\_\_
- 4. \_\_\_\_\_
- 5. \_\_\_\_\_

What specialists have you seen? (Indicate the year of consultation)

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

If you are female, are you currently pregnant? YES NO

**MEDICATIONS:**

Please list all **prescribed medications** you are presently taking. Indicate the name of the drug, dosage, duration of use, and reason for taking: \_\_\_\_\_

\_\_\_\_\_

List all **PAST prescribed medications** that you have taken for longer than 3 months:

\_\_\_\_\_

\_\_\_\_\_

Have you ever had an adverse reaction to any medication? Indicate the drug name and the reaction experienced

\_\_\_\_\_

How many times have you been treated with antibiotics in the past 5 years? \_\_\_\_\_

Please list any **over the counter medications** you presently take (e.g. Aspirin, Tums), and frequency of use:

\_\_\_\_\_

\_\_\_\_\_

Please list any vitamins/minerals, herbs or homeopathic remedies that you take more than occasionally:

\_\_\_\_\_

\_\_\_\_\_

**FAMILY MEDICAL HISTORY:**

Relation	Age	Health problems	Cause, if deceased
Father			
Mother			
Grandparents			
Siblings			
Children			

**MEDICAL HISTORY:**

Date of last physical exam: \_\_\_\_\_ For what reason? \_\_\_\_\_

Do you get regular SCREENING TESTS done by another doctor? (Pap, blood tests, etc.) YES NO  
Which ones? \_\_\_\_\_

Blood Type (circle one, if known): A B AB O Negative Positive

**PERSONAL HEALTH HABITS:**

Height: \_\_\_\_\_ Current weight: \_\_\_\_\_ Weight 1 year ago: \_\_\_\_\_ Max weight: \_\_\_\_\_ Year: \_\_\_\_\_

Smoker? YES NO Amount/day? \_\_\_\_\_ # Years smoked? \_\_\_\_\_ Year stopped? \_\_\_\_\_

Are you exposed to second hand smoke? YES NO Where? \_\_\_\_\_

Alcohol Use? YES NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Recreational drug use? YES NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Caffeine use (coffee, tea, pop)? YES NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

Amount of fluids/day: \_\_\_\_\_ Amount of water/day: \_\_\_\_\_

Are there any food groups that you avoid? YES NO If yes, please describe what group and why:

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

List any foods that you crave: \_\_\_\_\_

How many meals do you eat in a day? 1 2 3 4 more than 4

Are you frequently exposed to animals? YES NO What type? \_\_\_\_\_

Are you regularly exposed to toxins or other hazards? YES NO What kind? \_\_\_\_\_

\_\_\_\_\_

List all known allergies (food, environmental, etc.): \_\_\_\_\_

\_\_\_\_\_

Please describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Supper \_\_\_\_\_

Snacks including drinks \_\_\_\_\_

Do you exercise regularly? YES NO Type: \_\_\_\_\_ Frequency: \_\_\_\_\_

How many hours of sleep do you get per night? \_\_\_\_\_ Do you wake rested? YES NO

Do you have problems falling or staying asleep? \_\_\_\_\_

How many hours do you work each day? \_\_\_\_\_ Is it shift work? YES NO

Please rate your satisfaction with each of the following areas of your life: (4 = highest satisfaction)

HEALTH	0	1	2	3	4
DIET	0	1	2	3	4
LIFESTYLE	0	1	2	3	4
WORK	0	1	2	3	4
FAMILY	0	1	2	3	4
RELATIONSHIPS	0	1	2	3	4

Rate your stress level:    Low            Average            High            Very high            Unbearable

What areas of your life contribute most to your stress (please circle)?

Work            Health            Family            Money            Marriage            Other: \_\_\_\_\_

What do you do to deal with stress? \_\_\_\_\_

When was your last vacation? \_\_\_\_\_ How often do you take a vacation? \_\_\_\_\_

**CHRONOLOGICAL HEALTH HISTORY:**

This portion of the health history helps to establish patterns in your life that may be relevant to present health conditions. Please indicate below any accidents, broken bones, falls, illnesses, hospitalizations, surgeries, and any emotional stresses or traumas (deaths, loss of job, divorce, etc.)

- Age 0-4 \_\_\_\_\_
- Age 5-9 \_\_\_\_\_
- Age 10-15 \_\_\_\_\_
- Age 16-20 \_\_\_\_\_
- Age 21-25 \_\_\_\_\_
- Age 26-30 \_\_\_\_\_
- Age 31-35 \_\_\_\_\_
- Age 36-40 \_\_\_\_\_
- Age 41-45 \_\_\_\_\_
- Age 46-50 \_\_\_\_\_
- Age 51-55 \_\_\_\_\_
- Age 56-60 \_\_\_\_\_
- Age 61-65 \_\_\_\_\_
- Age 66-70 \_\_\_\_\_
- Age 71 + \_\_\_\_\_

What are your short-term health goals? \_\_\_\_\_

What are your long-term health goals? \_\_\_\_\_

Please list any other relevant health/ personal information that you feel is missing: \_\_\_\_\_

## SYSTEMS REVIEW

Below is a list of symptoms which may or may not seem relevant to your current health concerns. Please answer completely as a detailed health history is necessary to develop a personalized health plan. The relevant issues brought up by this questionnaire will be discussed during your appointment.

Please check (√) "C" if you currently have the symptom or "P" if you have had it in the past 6 months.

Skin	C	P
Rashes		
Hives		
Acne		
Boils		
Eczema		
Psoriasis		
Dry skin		
Itching		
Lumps		
Night sweats		
Other		

Head	C	P
Tension headaches		
Migraine headaches		
Head Injury		
Dizziness		
Other		

Eye	C	P
Impaired vision		
Use of contact lenses/ glasses		
Eye pain		
Tearing		
Dryness		
Double vision		
Glaucoma		
Cataracts		
Blurring		
Light Sensitivity		
Itching		
Redness		
Discharge		
Blind spot		
Other		

Ears	C	P
Impaired hearing		
Earache		
Dizziness		
Discharge		
Infections		
Excessive wax		
Other		

Nose & Sinuses	C	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Infections		
Other		

Mouth & Throat	C	P
Hoarseness		
Gum problems		
Difficulty swallowing		
Dental problems		
Sores		
Dryness		
Sore throat		
Loss of taste		
Other		

Neck	C	P
Lumps		
Swollen glands		
Goiter		
Pain or stiffness		
Other		

Respiratory	C	P
Cough		
Sputum		
Spitting up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Pain on breathing		
Shortness of breath		
Positive tuberculin test		
Last TB test		
Last chest x-ray		
Other		

Cardiovascular	C	P
Angina		
Murmurs		
Chest pain		
Swelling in ankles		
Palpitations, fluttering		
Last ECG		
Other		

Breasts	C	P
Do you perform self breast exams?		
Lumps		
Pain (or tenderness)		
Nipple discharge		
Last mammogram		
Other		

Gastrointestinal	C	P
Vomiting		
Heartburn		
Change in appetite		
Nausea		
Frequency of Bowel Movements per day	1	2 3+
Vomiting blood		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stools		
Hemorrhoids		
Black, tarry stool		
Jaundice		
Liver disease		
Gallbladder disease		
Food allergy		
Hiatus hernia		
Other		

Blood/Lymphatic	C	P
Anemia		
Easy bleeding/ bruising		
Past transfusions		
Lymph node swelling		
Other		

Please check (√) "C" if you currently have the symptom or "P" if you have had it in the past 6 months.

Urinary	C	P
Pain on urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced urine flow		
Other		

Musculoskeletal	C	P
Broken bones		
Muscle spasms/cramps		
Weakness		
Joint swelling		
Backache		
Other		

Peripheral vascular	C	P
Deep leg pain		
Cold hands/ feet		
Varicose veins		
Leg cramps		
Extremity numbness		
Extremity swelling		
Extremity ulcers		
Other		

Neurologic	C	P
Fainting		
Seizure/ Convulsions		
Paralysis		
Muscle weakness		
Numbness or tingling		
Loss of memory		
Involuntary movements		
Loss of balance		
Speech problems		
Other		

Endocrine	C	P
Heat/ cold intolerance		
Thyroid trouble		
Excessive thirst		
Excessive hunger		
Excessive sweating		
Diabetes		
Low blood sugar		
Other		

Emotional	C	P
Depression		
Extreme anger		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Insomnia		
Sexual difficulties		
Drug abuse		
Psychiatric care		
Psychological counselling		
Other		

Male Reproductive	C	P
Hernia		
Testicular mass		
Testicular pain		
Impotence		
Premature ejaculation		
Venereal disease		
Discharge of sores		
Sexually active		
Circle sexual preference: Heterosexual/ Homosexual/ Bisexual		
Last prostate exam:		
Last PSA level:		
Other		

Female Reproductive	C	P
Age of first menses:		
Last menstrual period:		
Number of days of menses:		
Length of cycle:		
Bleeding between periods		
Irregular cycles		
PMS		
Heavy flow		
Painful menses		
Menopause		
Age of onset:		
Hormone therapy		
Last gynecological exam:		
Number of pregnancies:		
Number of live births:		
Number of miscarriages:		
Number of abortions:		
Difficulty conceiving		
Vaginal discharge		
Vaginal itching		
Sexually active		
Pain during intercourse		
Circle sexual preference: Heterosexual/ Homosexual/ Bisexual		
Other		

**INFORMED CONSENT**

I would like to take this opportunity to welcome you to Haessler Naturopathic. This Clinic utilizes the principles and practices of Naturopathic Medicine and other supportive therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means. A number of different approaches may used: diet and nutritional supplements, botanical medicine, homeopathy, traditional Chinese medicine and acupuncture, physical medicine (Bowen therapy and hydrotherapy) and lifestyle counselling.

A thorough case history will be conducted by Jennifer Haessler, ND. A physical exam, specific blood and/or urinary laboratory reports may be used as part of the treatment work-up.

**Statement of Acknowledgement**

Printed name \_\_\_\_\_

As a patient of this clinic I understand that the form of medical care is based on Naturopathic and other supportative principles and practices. I recognize that even the gentlest therapies potentially have their complications in conditions such as diabetes, heart, liver or kidney disease, during pregnancy and lactation, in children, and while taking other medications. It is very important therefore that the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; and pain, fainting, bruising or injury from acupuncture.

As a patient of Jennifer Haessler, ND, I am at liberty to seek or continue medical care from a medical doctor or other health care provider licensed to practice in Ontario. This consent form is intended to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time. I understand that results are not guaranteed. I understand that treatment advice will not be given over the phone unless directly relating to specifics discussed during a clinic visit. I accept full responsibility for any fees incurred during care and treatment. I also understand the Haessler Naturopathic cancellation policy requires me to cancel a booked appointment 24 hours prior to that appointment. If I fail to do so, a cancellation fee of \$25 will be charged.

\_\_\_\_\_  
SIGNATURE

\_\_\_\_\_  
DATE

\_\_\_\_\_  
WITNESS