WOLFVILLE NATUROPATHIC CLINIC INC

Adult Female Intake Form

Name_____ Age____ Date of Birth_____ Country of Birth_____ Sex at birth_____
Address/Postal Code_____
Phone(H)_____ Phone(W)_____ Fax_____ Email_____
Occupation_____ Past Occupations_____
Marital Status/Relationship Status_____ Emergency Contact & Number_____
Number of children and ages_____ Religion/Personal Philosophy_____
Family Physician_____ Other Health Care Practitioners_____
How did you hear about this clinic? _____

Health Concerns (Please list in order of importance)

1.	**2.**	**3.**
4.	**5.**	**6.**

Medical History

Date of last physical exam_____ Height_____ Weight_____ Blood Type_____
Maximum Weight_____ Desired Weight (Explain)_____
Current Medications and Dosages_____
Past Medications_____
Do you have any known allergies? _____ To what? _____

Please circle which of the following childhood diseases you have had*: Measles German Measles Chicken Pox Mumps Whooping Cough Rheumatic Fever Diphtheria Scarlet Fever Polio Other*_____

♦Female Reproductive History:
Age of first menstrual period:_____ Approx Cycle length_____ Approx Period length_____ Regular pap tests? _____
History Abnormal paps? _____ Abnormal breast exams/mammograms? _____
History PMS Symptoms (moodiness, cramps, breast tenderness, etc)? Explain_____
_____
Have you ever been sexually active? Yes/No; History painful/difficult intercourse? Explain_____
What is your gender identity? (Circle) Male Female Transgender Male Transgender Female Gender Queer Other_____
What is your sexual orientation? (Circle) Straight Gay Lesbian Bisexual Other _____
Have you ever contracted a sexually transmitted disease? Yes/No; Which Disease(s)? _____
Current method of birth control (if applicable)_____Past methods_____
Number of live pregnancies & Maternal age_____ Miscarriages? _____ Abortions? _____
Menopausal history if applicable (Please give symptoms and ages)_____
_____

♦Traumas/Surgeries/Accidents/Diseases:
Please list all major accidents, hospitalizations, surgeries, diseases and traumatic events, and your age at the time:
Please continue on the back of this page if you require additional space.

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	
7.		8.	

Family Medical History: Please check the appropriate box if you or a family member have had the following:

	You	Mother	Father	Sister/Brother	Grandparents
Cancer (Give type)					
Tuberculosis/Lung Disease					
Heart Disease/Angina					
High Blood Pressure					
Asthma/Allergies					
Eczema/Psoriasis					
Arthritis (Osteo or Rheumatoid)					
Diabetes					
Kidney Disease					
Anemia					
Autoimmune Disease (Lupus, etc)					
Chronic Fatigue/Fibromyalgia					
Depression/Mood swings					
Schizophrenia/Delusions/Alzheimer's					
Osteoporosis					
Thyroid:					
Other:					

Lifestyle

Do you smoke?_____ How many cigarettes/day?_____ Have you ever used recreational drugs?_____
Do you drink alcohol?_____ How many drinks per day?_____ How many drinks per week?_____
Have you ever been treated for an addiction to drugs, alcohol, or prescription medications?_____
How many times per week do you exercise?_____ What form of exercise?_____
How many hours do you sleep per night_____ Do you have difficulty falling asleep?_____
How often do you wake through the night?_____ Do you awake in the morning feeling rested_____
On a scale of 1-10 (10 is highest) what is your energy like in the (a) *morning*_____ (b) *afternoon*_____ (c) *evening*_____
Please list the top three sources of stress in your life: 1)_____ 2)_____ 3)_____
Do you ever suffer from depression? (Explain)_____
Do you ever suffer from mood swings? (Explain)_____
Are you/Have you ever been a victim of mental, emotional, or sexual abuse? _____
Have you ever had psychiatric/psychological counseling?_____
Do you have unresolved emotional issues or grief (Explain)_____
_____
How content are you with your life? (Explain)_____
What would you like to change about your life?_____
What do you do in your leisure time?_____

Environment

Do you have any pets?_____ Do you have seasonal allergies?_____
Are you affected by scented products/perfumes?_____ Molds?_____
Do you live in an apartment?_____ Basement?_____ Home?_____
Do you live in a town?_____ On a rural street?_____ Near/On a farm?_____ Near a golf course?_____
Approximately what year was your home or dwelling built?_____ How is it heated?_____
Are chemicals used on your lawn/garden?_____ What is your source of drinking water?_____
Are you exposed to any chemicals/hazardous materials on a daily basis?_____
Can you think of anything in your home/work environment which might adversely affect your health/well-being?
(Explain)_____
_____

Is there anything else that you feel I should know about you? (Please continue on the back of this page)