*Welcome to Women's Health, Naturally. Our philosophy and approach to care is holistic and seeks to understand all the factors that may be affecting your health. This intake form will help us uncover the root cause of your health concerns. Please fill out as much of it as possible before your appointment. We look forward to meeting you.*

# PATIENT INTAKE FORM

Name: _____
(Last name) (First) (Initial)

Date of Birth: _____ Sex: Male Female
(Day/Month/Year)

Occupation: _____

Level of formal education: _____

Contact Information:
**Please inform the clinic if your contact information changes**

Address: _____
(Street and number) (City) (State) (Post code)

Phone: _____
(Daytime) (Evening) (Fax)

Email: _____

Emergency contact: _____
(Name) (Relationship)

_____
(Daytime phone number) (Evening phone number)

| | |
|---|---|
| Have you previously received Naturopathic care? | |
| How did you hear about our clinic? | |

We are deeply appreciative when family, friends and healthcare providers refer people to our clinic. So that we can thank them, please provide us with their name and address:

Referred by: _____
(Name) (Address)

## Goals and Expectations

What are your goals for your health? _____

_____

What are your goals for today's consultation? _____

_____

How do you rate your present level of health? (Poor) 1 2 3 4 5 6 7 8 9 10 (Excellent)

How committed are you to improving your health? (Not at all) 1 2 3 4 5 6 7 8 9 10 (Absolutely)

What are the main reasons you have sought naturopathic care for? Tick as many as you wish:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Weight Loss | ☐ | Disease prevention | ☐ | Pre-conception care | ☐ | Cardiovascular protection | ☐ |
| Diet | ☐ | Energy | ☐ | Immune System | ☐ | Sports enhancement | ☐ |
| Specific health concern | ☐ | Other, Please list: | ☐ | | | | |

**YOUR HEALTHCARE PROVIDERS**

Who is your GP?

(Name) (Address)

When was your last physical exam?

(Month) (Year)

When did you last have blood tests?

Who is your dentist?

(Name) (Address)

When did you last visit your dentist?

(Month) (Year)

Are you currently under the care of a specialist? If so:

(Name) (Address)

Are you currently under the care of an alternative healthcare provider e.g. acupuncturist, chiropractor, massage therapist?

1. Type: Name: Address:
2. Type: Name: Address:
3. Type: Name: Address:

**HEALTH CONCERNS**

Please list any health concerns in order of importance:

1. (Describe your condition)

When did it start?

Has this condition been diagnosed? Yes / No (Diagnosis)

Are you receiving treatment of any kind for this condition? Please describe:

2. (Describe your condition)

When did it start?

Has this condition been diagnosed? Yes / No (Diagnosis)

Are you receiving treatment of any kind for this condition? Please describe:

3. (Describe your condition)

When did it start?

Has this condition been diagnosed? Yes / No (Diagnosis)

Are you receiving treatment of any kind for this condition? Please describe:

4. (Describe your condition)

When did it start?

Has this condition been diagnosed? Yes / No (Diagnosis)

Are you receiving treatment of any kind for this condition? Please describe:

5.
(Describe your condition)

When did it start?

Has this condition been diagnosed? Yes / No

(Diagnosis)

Are you receiving treatment of any kind for this condition? Please describe:

**MEDICATIONS**

What medications are you currently taking? Your list should include: prescription and over-the-counter drugs; birth control pills; herbal remedies; vitamins and any other supplements.

| Pharmaceutical drug or supplement (for supplements, please include the brand) | How much do you take per day? | Why are you taking this medication? |
|---|---|---|
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Have you ever used or been treated with any of the following?

| | | | |
|---|---|---|---|
| Antibiotics | ☐ | Antacids | ☐ |
| Cortisone or other steroids | ☐ | Chemotherapy / radiation | ☐ |
| Antihistamines | ☐ | Pain relievers (aspirin, ibuprofen) | ☐ |
| Drugs for arthritis (Vioxx, Celebrex) | ☐ | Hormone therapy (including fertility treatments) | ☐ |
| Thyroid medication | ☐ | Recreational drugs | ☐ |
| Laxatives or stool softeners | ☐ | Blood thinners | ☐ |
| Anti-depressants | ☐ | Stimulants | ☐ |
| Flu vaccination | ☐ | Diuretics | ☐ |
| Vaccination for foreign travel | ☐ | Anaethesia | ☐ |
| Sleeping pills or sedatives | ☐ | Epidural | ☐ |

**ADVERSE REACTIONS TO MEDICATIONS**

Please describe any adverse reactions you have had to

- prescription drugs, over-the-counter drugs or recreational drugs
- vaccinations (childhood, travel, flu, hepatitis)
- natural medicines (herbs, vitamins, minerals, homeopathics)

| Name of drug, vaccine or natural medicine | Describe the reaction |
|---|---|
| 1. | |
| 2. | |
| 3. | |
| 4. | |
| 5. | |
| 6. | |

**TOXIN EXPOSURE**

| | | |
|---|---|---|
| Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations) or at work or while traveling ? | Y | N |
| Have you ever experienced health problems after putting down new carpeting, painting your home, doing renovations or having your lawn sprayed with herbicide? | Y | N |
| Are you particularly sensitive to perfume, petrol or other vapours? | Y | N |
| Have you ever lived near a refinery or a polluted area? | Y | N |
| Have you ever lived in a home more than 50 years old? | Y | N |
| Do you have mercury dental fillings? | Y | N |
| Have you had any dental root canal procedures? | Y | N |
| Do you have any surgical implants (cosmetic, medical)? | Y | N |
| Do you live near power lines? | Y | N |

Please list any **allergies** or sensitivities (food, pollen, mold, animals, chemicals) you suffer from or have previously experienced

| Allergy | Age of onset |
|---|---|
| | |
| | |
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| | |

List all **surgeries** you have had.

| Procedure | Year | Complications? |
|---|---|---|
| | | |
| | | |
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List all **hospitalizations.**

| Reason | Year | Outcome |
|---|---|---|
| | | |
| | | |
| | | |
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| | | |

List any major injuries you have sustained

| Injury | Year | Outcome |
|---|---|---|
| | | |
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If you are currently experiencing or have experienced any of the following, place a checkmark in the corresponding box

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Acne | ☐ | Gall stones | ☐ | Measles | ☐ | Polycystic Ovaries | ☐ |
| Anaemia | ☐ | German Measles | ☐ | Memory Loss | ☐ | Psoriasis | ☐ |
| Angina / heart attack | ☐ | Glaucoma | ☐ | Meningitis | ☐ | Rheumatic fever | ☐ |
| Appendicitis | ☐ | Gonorrhea | ☐ | Mental illness | ☐ | Rubella | ☐ |
| Arthritis | ☐ | Gout | ☐ | Miscarriage | ☐ | Scarlet fever | ☐ |
| Asthma | ☐ | Head injury | ☐ | Mononucleosis | ☐ | Sickle Cell Anemia | ☐ |
| Bleeding disorder | ☐ | Headaches / migraines | ☐ | Multiple Sclerosis | ☐ | Strep throat | ☐ |
| Cancer | ☐ | Heart disease | ☐ | Nasal Polyps | ☐ | Stroke | ☐ |
| Cervical Dysplasia | ☐ | Haemorrhoids | ☐ | Nerve damage | ☐ | Syphilis | ☐ |
| Chicken pox | ☐ | Hepatitis | ☐ | Osteoporosis | ☐ | Thyroid imbalance | ☐ |
| Chronic bronchitis | ☐ | High blood pressure | ☐ | Other STDs | ☐ | Tuberculosis | ☐ |
| Diabetes | ☐ | High cholesterol | ☐ | Varicose veins | ☐ | Digestive disorders | ☐ |
| HIV | ☐ | Whooping cough | ☐ | Diphtheria | ☐ | Hives | ☐ |
| Parasites | ☐ | Ectopic Pregnancy | ☐ | HPV | ☐ | Pelvic | ☐ |
| Eczema | ☐ | Kidney Disease | ☐ | Endometriosis | ☐ | Kidney stones | ☐ |
| Pleurisy | ☐ | Epilepsy | ☐ | Lyme disease | ☐ | Pneumonia | ☐ |

**REVIEW OF SYSTEMS**

*Please place a checkmark in the corresponding box if you have experienced or are currently experiencing any of the following:*

**Mental Emotional**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Abuse | ☐ | Easily anger | ☐ | Mental illness | ☐ | Prolonged sadness or grief | ☐ |
| Anxiety or nervousness | ☐ | Indecision | ☐ | Mood swings | ☐ | Irritability | ☐ |
| Panic attacks | ☐ | Depression | ☐ | Memory problems | ☐ | Phobias | ☐ |

What were the four most stressful events in your life? Are any of these still affecting you?

1. _____
2. _____
3. _____
4. _____

Has there been an event or sickness that you have never fully recovered from?

_____

## Endocrine

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| 10 kg change in weight | ☐ | Poor concentration | ☐ | Generally feel hot | ☐ | Hypoglycemia (low blood sugar) | ☐ |
| Sluggish after coffee | ☐ | Generally feel cold | ☐ | Sluggish after eating | ☐ | Mental dullness | ☐ |

Rate your energy level between 1 and 10 (extreme fatigue) 1 2 3 4 5 6 7 8 9 10 (vital)
Rate your stress level between 1 and 10 (relaxed) 1 2 3 4 5 6 7 8 9 10 (extremely stressed)

At what time of day is your energy the best? _____
At what time of day is your energy the worst? _____
Have you recently lost or gained weight? Yes / No
How many hours of sleep do you get a night? _____
Do you have trouble getting to sleep? _____
Do you wake during the night and have trouble getting back to sleep? _____
How many times and for how long? _____
Do you wake feeling rested?

## Immune

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chronic infections | ☐ | Frequent colds & flus | ☐ | Swollen glands | ☐ | Lymph nodes | ☐ |
| Slow wound healing | ☐ | Frequent antibiotics | ☐ | Frequent sore throat | ☐ | Cold sores | ☐ |
| Shingles | ☐ | | | | | | |

## Neurologic

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Paralysis | ☐ | Muscle weakness | ☐ | Loss of memory | ☐ | Vertigo | ☐ |
| Dizziness | ☐ | Numbness | ☐ | Tingling | ☐ | Loss of balance | ☐ |

## Skin Hair and Nails

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Rashes | ☐ | Itching | ☐ | Brittle nails | ☐ | Night sweats | ☐ |
| Lumps or abscesses | ☐ | Change in the size, shape or colour of a mole or freckle | ☐ | Dry skin | ☐ | White spots on nails | ☐ |
| Excessive perspiration | ☐ | Strong body odour | ☐ | Warts | ☐ | | |

How many times have you had sunburn? _____

## Head, Ears, Eyes, Nose, Throat

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Headaches | ☐ | Migraine headaches | ☐ | Jaw pain or clicking | ☐ | Nearsighted | ☐ |
| Cataracts | ☐ | Visual disturbances | ☐ | Excessive tearing | ☐ | Dry eyes | ☐ |
| Colour blindness | ☐ | Ringing in ears | ☐ | Earaches | ☐ | Impaired hearing | ☐ |
| Nose bleeds | ☐ | Poor sense of smell | ☐ | Post nasal drip | ☐ | Loss of smell | ☐ |
| Gum problems | ☐ | Hoarseness | ☐ | Teeth grinding | ☐ | Itchy ear canal | ☐ |
| Poor night vision | ☐ | Far sighted | ☐ | Runny nose | ☐ | Breathe through your mouth | ☐ |

## Respiratory System

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chronic cough | ☐ | Chronic phlegm | ☐ | Cough up blood | ☐ | Wheezing phlegm that is green of yellow | ☐ |
| Shortness of breath lying down | ☐ | Pain while breathing | ☐ | | ☐ | Shortness of breath during day | ☐ |

## Cardiovascular System

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Chest pain | ☐ | Fainting | ☐ | Cold hands and feet | ☐ | Heaviness or pain in legs | ☐ |
| Hemorrhoids | ☐ | Heart palpitations | ☐ | Your socks leave imprints on your ankles | ☐ | You feel dizzy when you stand up quickly | ☐ |
| Easy bleeding /bruising | ☐ | Varicose veins | ☐ | Heart murmurs | ☐ | | |

### Gastrointestinal System

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Trouble swallowing | ☐ | Heartburn | ☐ | Change in thirst | ☐ | Change in appetite | ☐ |
| Nausea | ☐ | Bloating | ☐ | Gas | ☐ | Burping | ☐ |
| Blood in stools or on tissue | ☐ | Stomach cramps or pain | ☐ | Constipation | ☐ | Diarrhoea or loose stool | ☐ |
| Black stool | ☐ | Mucous in stool | ☐ | Itching around rectum | ☐ | Undigested food in stool | ☐ |
| Hard stool | ☐ | Stool floats in bowl | ☐ | Grey stool | ☐ | | |

How often do you have a bowel movement? _____

Have you ever traveled to a third-world country? If so, for how long?

_____

Have you ever had parasites that you are aware of?

_____

### Urinary

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pain on urination | ☐ | Strong urine odour | ☐ | Frequent bladder infections | ☐ | Inability to hold | ☐ |
| Increased frequency | ☐ | Kidney infections | ☐ | Must strain to urinate | ☐ | Awaken to urinate | ☐ |
| Pain on urination | ☐ | | ☐ | | ☐ | | ☐ |

### Male Reproductive

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Hernia | ☐ | Testicular mass | ☐ | Testicular pain | ☐ | Low sex drive | ☐ |
| Discharge or sores | ☐ | Sexual difficulties | ☐ | Impotence | ☐ | Prostate condition | ☐ |

What is your sexual orientation? _____

Are you sexually active? _____

When was your last prostate exam? _____

### Female Reproduction

Age of first menses _____

Age of last menses _____

How long is your cycle (in days)? _____

How many days is your menses? _____

Number of pregnancies? _____

Are you pregnant? _____

Are you trying to conceive? _____

What type of birth control do you use (if any)? _____

Are you sexually active? _____

What is your sexual orientation? _____

### Gynecological Health

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Vaginal discharge | ☐ | Abnormal pap tests | ☐ | Pain during intercourse | ☐ | Abortions | ☐ |
| Itching | ☐ | Sexual difficulties | ☐ | Miscarriages | ☐ | STDs | ☐ |
| Genital warts | ☐ | Hysterectomy | ☐ | Ovarian cysts | ☐ | Endometriosis | ☐ |
| Abdominal pain | ☐ | Mid cycle sores | ☐ | Growths or lumps | ☐ | Menopausal symptoms | ☐ |
| Low sex drive | ☐ | Use tampons | ☐ | Frequent thrush | ☐ | Vaginal dryness | ☐ |
| Odour | ☐ | | | | | Hot flushes | ☐ |

When was your last pap test? _____

**Pre Menstrual and Menstrual Symptoms**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Pain of cramping | ☐ | Irregular cycles | ☐ | Heavy flow | ☐ | Clotting | ☐ |
| Flow more than 5 days | ☐ | Flow less than 5 days | ☐ | Light flow | ☐ | Missed periods | ☐ |
| Bleeding between periods | ☐ | Mood swings | ☐ | Diarrhoea | ☐ | Bloating | ☐ |
| Headaches | ☐ | Water retention | ☐ | Breast tenderness | ☐ | Cravings | ☐ |
| Low back ache | ☐ | | | | | | |

**Breast Health**

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Fibrocystic breasts | ☐ | Nipple discharge | ☐ | Flaky dry skin on nipple | ☐ | Breast lump | ☐ |
| Puckering of skin | ☐ | Tenderness | ☐ | | ☐ | | ☐ |

Do you perform monthly self breast exams? Yes / No
When was your last breast exam? _____
Do you have regular mammograms? _____

**LIFESTYLE**

Have you ever smoked cigarettes? If so how many packs a day? _____
How long have you smoked? _____
Are you exposed to second hand smoke? _____
How often do you drink alcohol and how much do you drink? _____
Do you use recreational drugs? _____
How often do you exercise? _____
What kind of exercise do you do? _____
How much time do you spend outdoors per week? _____
What do you do to relax? _____
Describe your support network _____
Describe your living situation _____
Do you have a spiritual practice? _____

**DIET**

What type of water do you drink? _____
How much water do you drink per day? _____
How many times a week do you eat dairy products? _____
How many times per week do you eat red meat? _____
How many times per week do you eat fish? _____
How many times per week do you eat fruit? _____
How many times per week do you eat vegetables? _____
Do you eat organic food? _____
How often do you eat out? _____
What foods do you crave? _____
How many soft drinks, coffees and teas do you drink per day? _____
Coffee…… (no. of sugars) ……..
Tea…… (no. of sugars) …….
Soft drinks……..

Do you have any dietary restrictions? (vegetarian, religious, allergies) _____

How often do you eat chips, lollies, biscuits, cakes? _____

**FAMILY HEALTH HISTORY**

Please indicate which of the below have affected any of your relatives:

| | | | | | | | |
|---|---|---|---|---|---|---|---|
| Alcoholism | ☐ | Cancer | ☐ | Gout | ☐ | Tuberculosis | ☐ |
| Allergies | ☐ | Depression | ☐ | Heart disease | ☐ | Neurological disorder | ☐ |
| Eczema | ☐ | Other skin condition | ☐ | High blood pressure | ☐ | Cholesterol | ☐ |
| Mental illness | ☐ | Diabetes | ☐ | Paralysis | ☐ | Syphilis | ☐ |
| Arthritis | ☐ | Epilepsy | ☐ | Gonorrhea | ☐ | Asthma | ☐ |

| Relative | Age if alive | Age at death | Ailments |
|---|---|---|---|
| Mother | | | |
| Father | | | |
| Sisters | | | |
| Brothers | | | |
| Maternal Grandmother | | | |
| Maternal Grandfather | | | |
| Maternal Aunts / Uncles | | | |
| Paternal Grandmother | | | |
| Paternal Grandfather | | | |
| Paternal aunts / Uncles | | | |

Thank you for taking the time to fill out this form. All information contained herein is strictly confidential.

So that our naturopath can prepare for your visit, please email these completed forms to us **before** your arrival.
Email: info@womenshealthnaturally.com.au

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