211-3885 Duke of York Blvd., Mississauga ON L5B 0E4 T:(905)276-6800 F:(905)276-6802

ADULT INTAKE FORM

Name: _____ _____ Date:_____
(First) (Last)
Date of Birth: _____ (Y/M/D) Sex: □ F □ M

Address:_____ Appt # : _____

City: _____ Province: _____ Postal Code: _____

Contact Phone Numbers:
Home: _____ Work: _____ Cell: _____
May we leave messages relating to your visits? □ Y □ N
Email Address: _____

Emergency Contact:
Name: _____ Relation: _____ Phone: _____

How did you hear about Natura Wellness Clinic?
_____

If you were referred, please indicate the name of the person who referred you: _____
_____

Medical/family Doctor: _____ Permission to contact them? □ Y □ N

Telephone: _____ Fax: _____

Date of last visit? _____

Other health care provider you are seeing? _____

Telephone: _____ Fax: _____

Permission to contact them? □ Y □ N

Date of last visit? _____

What are your health concerns in order of importance?

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

If you are female, are you currently pregnant? □ Y □ N Or trying to get pregnant? □ Y □ N

Please indicate any serious condition, illness, injuries, or hospitalization:

1. _____ Date: _____
2. _____ Date: _____
3. _____ Date: _____
4. _____ Date: _____

Do you have any allergies that you are aware of? (medication, environmental, food, pet, etc.)

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

Please list all medications (prescriptions, over the counter, vitamins, herbs, homeopathics, etc):

Past Medications	Current Medications

Do you get regular physical screenings done by another doctor? □ Y □ N
When was your last physical screening? _____

Do you take any of the following regularly?

□ Aspirin/ASA □ Tylenol/Acetaminophen □ Advil/Ibuprofen
□ Laxatives □ Birth Control Pills □ Antacids
□ Diet pills

Have you been treated with antibiotics? □ Y □ N If yes, how many times? _____

Please indicate if you use any of the following and frequency of use?

Substance	Yes	No	Frequency per day or week
Caffeine			
Alcohol			
Tobacco			
Recreational drugs			

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Do you have any dietary restrictions (allergies, religious, vegetarian, vegan, etc.)?

_____

Describe a typical day's diet:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Has anyone in your family had any of the following conditions, if yes please indicate which family member?

Condition	Family Member(s)
Alcoholism	
Allergy	
Asthma	
Autoimmune disorder	
Cancer	
Depression	
Diabetes	
Drug Abuse	
Heart Disease	
High Blood Pressure	
Kidney Disease	
Other Mental Illness	
Thyroid Dysfunction	
Other	

□ I don't know my family history

What is your marital status? _____

What is your occupation? _____

Do you exercise regularly? □ Y □ N If yes, what type of exercise and how often per week? _____

Are you exposed to tobacco smoke regularly? (home, work, etc.) □ Y □ N

Are you frequently exposed to animals? □ Y □ N

Are you frequently exposed to toxins and other hazards? (home, work, etc.) □ Y □ N

Would you say you have good energy levels? □ Y □ N

Would you say you sleep well? □ Y □ N

Does your daily routine consist of a lot of stress? □ Y □ N

Is there anything you feel is important that has not been covered yet?

_____

_____

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