Adult Intake Form for Dr. Cheryl Cooper, ND

Today's Date (MM/DD/YYRR): ____

Name: ____

Address: ____

City: _________________________Province: _________Postal Code: ______________________

Home Phone #: ____

Cell #: ____

Office # ______________________________________extension: ___________________

Preferred contact method? ☐ Home # ☐ Cell # ☐ Work # ☐ Email

Email: ____

Sex: M_______F_______ Birthdate (MM/DD/YYRR): _______________________

How did you hear about us?

Family/Friend ____

Other Health Care Provider _______________________________

Sign ________

Advertisement _______

Vitallife Web Site _______

Google Search ________

Other Internet site (which one?) ______________________

Other (please provide details) __________________________________

Adult Naturopathic Intake Form

Occupation: ___________________________________ Employer: ____
Status: Single___ Married ___ Divorced ___ Living with Partner ___ Widowed ___ Other ___
Do you have children? Yes _____ No _____
If yes, list name, age and sex. _______________, _______________, _______________, ________________

Religion/Spirituality?____

Emergency Contact: ____
(last name) (first name)

____
(day phone) (evening phone)

When was your last physical exam? ____

Did you have bloodwork or other tests done at that time? ____

Who are your other health care providers?

____
(name) (phone) (fax)

____
(name) (phone) (fax)

____
(name) (phone) (fax)

Please list your health concerns in order of importance to you.

Concern	Since	Concern	Since
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please indicate any treatment or testing you have had or are currently receiving for the above concerns.

____
____
____

GENERAL HEALTH HISTORY

Height __________ Current Weight _______________ Weight change in the past year? _____________
Maximum weight?______________When? _______________
Minimum weight?______________When?________________
What do you feel is the most comfortable weight for you?___________________
When is the last time you were at this weight?_____________________
How many colds, flus, and/or other acute illnesses have you had in the past year? ____
What were they and when did you have them?

Type	When

How would you rate your energy on a scale of 1-10, with 10 being the most energy? /10
Is there a time of day when your energy is better? ______________ worse? ________________

How many hours of sleep do you get per night on average? ________________
Do you have trouble getting to sleep? Yes / No / Sometimes
If so, why? ____
Do you ever take anything to help you sleep? Yes / No / Sometimes
If yes, what? ____
Do you wake up during the night? Yes / No / Sometimes
If yes, at what time do you typically wake up? ____________________
Why do you wake up? ____
Are you able to get back to sleep right away? Yes / No / Sometimes
If not, what do you do? _______________________________________
Do you feel rested on waking? Yes / No / Sometimes
Do you take naps? Yes / No / Sometimes
Do you remember your dreams? Yes/No
If yes, describe the nature of your dreams? ____

MEDICAL HISTORY

Please check the conditions you have had (P) or currently have (C).

Alcoholism		Depression		Ulcers	
Allergies		Diabetes		Kidney Disease	
Anemia		Drug use		Liver Disease/Jaundice	
Anxiety		Eczema		Overweight	
Asthma		Emphysema		Pneumonia	
Arthritis		Headaches/Migraine		Rheumatism	
Bleeding		Heart Murmur		Tuberculosis	
Cancer		High Blood Pressure		Other	
Candida		Hyperthyroid			
Colitis/Crohn's		Hypothyroid			

Please list any major trauma, stresses, injury, or accident you have experienced in your life.

Trauma	Year	Long-term effects

Please list any surgical procedures you have undergone.

Procedure	Year	Complications

Please list other forms of treatment that you have used and describe their effectiveness.

Form of Treatment	Effectiveness

ALLERGIES AND SENSITIVIES

Please list any allergies, sensitivities and/or intolerances that you are aware of.

Medications	Food	Environmental/Chemical

Are you aware that you have ever been exposed to toxic substances such as chemicals pesticides, herbicides, solvents, or sprays, at home or at work? Yes / No

If yes, please give details: ______

Are you aware that you have ever been exposed to heavy metals such as lead, mercury, arsenic or cadmium? Yes / No

If yes, please give details: ______

Please answer yes or no to the following questions. If you answered yes, please explain.

Have you ever had to lower the regular dose of prescription medication, over-the counter medication or herbal supplementation because you were too sensitive to the regular dose? Yes / No

Which medications? ______

Do you avoid caffeine in the afternoon or altogether because it keeps you up at night? Yes / No

Do you smell odours others cannot? Yes / No

If so, which odours? ______

Do you have a sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? Yes / No

If so, which ones? ______

MEDICATIONS / SUPPLEMENTS

Please list all present medications and supplements including drugs, herbs, vitamins, minerals, homeopathics, bach flower remedies and Chinese herbal remedies.

Name of Supplement/Medication	Amount Taking and How Often	For what?	How long for?

Which of the following have you used / currently use? Please include amount, frequency and length of use; use **P** to indicate past use and **C** for current use.

Tobacco		Alcohol	
Recreational drugs		Steroids	
Cortisone		Laxatives	
Sedatives		Pain Relievers	
Coffee		Anti-Inflammatories	
Diet Pills		Other	

Have you ever taken antibiotics? Yes / No
If yes, what kind, when and for what?

___

___

FAMILY HISTORY

Please indicate any health conditions for the following family members:

	Mother	Father	Siblings	Grandparents	Other blood relatives
Cancer					
Heart disease					
Arthritis					
TB					
Diabetes					
Asthma					
Allergies					
Food sensitivities					
Digestive issues					
Celiac disease					
Crohn's/colitis					
Thyroid					
Autoimmune					
Kidney disease					
Depression/anxiety					
Anemia					
Stroke					
Seizures					
High blood pressure					
Other					

FOOD AND DIGESTION

How much water do you drink daily? ___

What other beverages do you drink, and how much: ___

Do you prefer your beverages hot, cold, or neutral: ___

How often do you have a bowel movement? ___

Do you have any issues with digestion (ie heartburn, gas, bloating, indigestion)? ___

List the primary foods included in your diet for:

Breakfast	
Lunch	
Dinner	
Snacks	

Are there any foods you exclude from your diet? Why? ____________________

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy) ____________________

WORK AND LIFESTYLE

Do you enjoy your work? Yes / No

What do you like and/or dislike about your work? ____________________

Are you currently in a relationship? Yes / No

For how long? ____________

If so, are you happy with your relationship? Yes / No

Do you have a supportive family or friends who are there when you need them? Yes / No

Does your family live near enough to you that you can see them regularly? Yes / No

Do you exercise? Yes / No

If yes, what kind and how often? ____________________

What do you do in your spare time? ____________________

What are your interests and hobbies? ____________________

How often do you enjoy them? ____________________

What do you do for yourself? ____________________

SEXUALITY

Now	Past		Now	Past	
		Excessive sexual desire			Lack of sexual desire
		Sexually transmitted disease			Multiple partners
		Pain during intercourse			Sexual dysfunction
		Uncomfortable with sexuality			

Are you currently sexually active? YES / NO

What type of birth control and/or sexual protection do you use?____________________

Do you use sexual protection consistently? YES / NO

Sexual preference: Heterosexual ________

Homosexual ________

Bisexual ________

MALE REPRODUCTIVE SYSTEM (if applicable)

Now	Past		Now	Past	
		Prostate problems			Sores on penis
		Difficulty getting an erection			Discharge from penis
		Painful erection			Premature ejaculation
		Swelling/lumps in testicles			Difficulty with ejaculation
		Testicular pain			Infertility
		Other sexual difficulties			

Date of last prostate exam?______________________

FEMALE REPRODUCTIVE SYSTEM (if applicable)

Now	Past		Now	Past	
		Breast pain/tenderness			Painful intercourse
		Breast lumps			Vaginal discharge
		Nipple discharge			Vaginal dryness
		Pelvic Pain			Vaginal itching/burning
		PMS			Genital eruptions
		Spotting/bleeding between periods			Excessive menstruation
		Never/seldom orgasmic			Absent menstruation
		Birth Control Pills			Abnormal PAP test
		Pain before menses			Pain during menses
		Pain after menses			Clots during menses
		Moodiness			Fluid retention
		Sexual difficulties			Endometriosis
		Cysts			

Average number of days period lasts for?__________

Average number of days of cycle?_________

Date of last period?______________

Number of pregnancies___________

Number of live births ___________

Number of miscarriages__________

Number of terminated pregnancies________________

Have you had any difficulty conceiving? YES / NO / NA

Date of last gynecological exam/PAP test?_________________

Date of last breast exam?_____ Mammogram?___________ Thermography? ___________

Regular breast self-exams? YES / NO

ADDITIONAL

Is there any other information relevant to your health that has not been addressed?

____

____

____

____

Use the back of this page to describe yourself in words or pictures.

Thank you for taking the time to complete these forms.