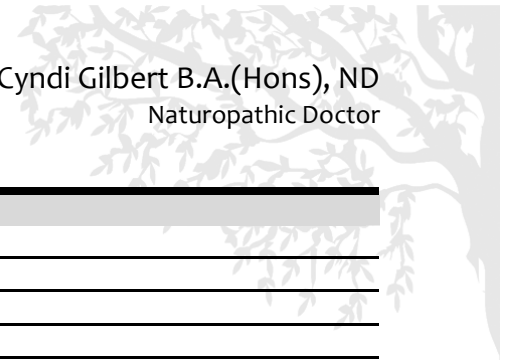


Adult Intake Form

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Cyndi Gilbert B.A.(Hons), ND
Naturopathic Doctor



FEMALE REPRODUCTIVE – If applicable

Is there a chance you are currently pregnant? Y/N _____
Are you currently breastfeeding? Y/N _____
Do you perform monthly breast self-exams? Y/N _____
History of breast lumps, cysts, or masses? Y/N _____
Do you have annual PAP tests? Y/N _____ Date of last PAP: _____
History of abnormal PAP(s)? _____ If yes, date of abnormal PAP(s): _____

MALE REPRODUCTIVE – If applicable

Do you have annual digital rectal exams (DRE)? Y/N _____
Date of last digital rectal exam (DRE): _____
Difficulties obtaining/maintaining erections and/or ejaculating? If yes, please explain. _____

Difficulties with conception? If yes, please explain. _____

Do you perform monthly testicular self-exams? Y/N _____
History of testicular lumps, cysts, or masses? Y/N _____

CHEMICAL / ENVIRONMENTAL EXPOSURES

Have you ever been exposed to toxic substances such as pesticides, herbicides, solvents, sprays, or heavy metals? If yes, please give details. _____

Do you avoid caffeine because it keeps you up at night? _____
Do you sense odours that others cannot? Which ones? _____
Have you ever had to decrease the dose of prescription, over-the-counter or herbal medicines because of being sensitive to the original dose? If yes, please give details. _____

Are you frequently exposed to animals? If yes, please give details. _____

OTHER CONCERNS – Please list any other information relevant to your health that has not been addressed.

This is to certify that I have answered the questions on the form to the best of my knowledge. I understand that to provide incorrect information about my health and/or symptoms may place my health at risk.

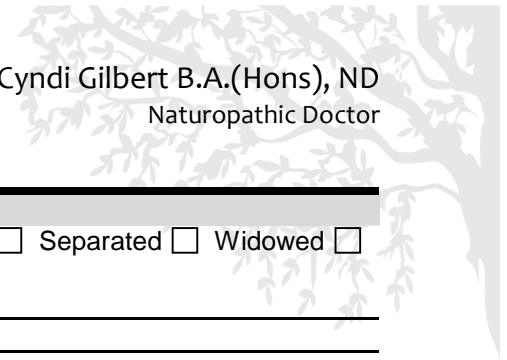
Signature

Date

Adult Intake Form

- Page 3 of 4 -

Cyndi Gilbert B.A.(Hons), ND
Naturopathic Doctor



SOCIAL HISTORY & LIFESTYLE

Marital Status: Single Living with Partner Married Divorced Separated Widowed

Children? If yes, please list age and sex of each child _____

Sexual Orientation: _____

How would you describe the emotional climate of your home? _____

Occupation: _____ Hours per week worked: _____

Do you enjoy your work? _____

Hobbies: _____ How often? _____

Do you exercise? If yes, what forms? _____ How often? _____

Average hours of sleep / night? _____ Ideal hours of sleep / night? _____

Difficulty falling asleep? Y/N _____ Wake rested? Y/N _____

Take naps? _____ Wake during the night? If so, why? _____

What are the major sources of stress in your life and how do you cope with them? _____

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (please list) _____

What behaviours or lifestyle habits do you currently engage in regularly that you believe are self-destructive? (please list) _____

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you? _____

What do you love to do? _____

DIET AND METABOLISM- Please recall a typical 24 hour period

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

How much water do you drink per day? _____

Any food cravings? _____ Aversions? _____

Dietary restrictions (e.g. religious, vegetarian)? _____

Height: _____ Weight: _____ Desired weight: _____ Weight 1 year ago: _____

Frequency of urination Per day: _____ Per night: _____

Frequency of bowel movements per day / week: _____

FEMALE REPRODUCTIVE - If applicable

Age at menarche (1st menses): _____ Age at menopause (if applicable): _____

Average # of days of menstrual flow: _____ Average # of days in cycle: _____

Date of last menses: _____ # of pregnancies: _____ # of live births: _____

History of miscarriage or abortion? If yes, please explain. _____

Difficulties with conception? If yes, please explain. _____

CURRENT MEDICATIONS & SUPPLEMENTS – Please include all prescription drugs, over the counter drugs (aspirin, antacids, laxatives, etc.), birth control pills, herbs, vitamins, minerals, homeopathics, etc.

List	Dose	Reason for taking	Date Started	Side Effects

PAST MEDICATIONS AND SUPPLEMENTS

List	Dose	Reason for taking	Dates	Side Effects

of courses of Antibiotics: _____
 Most recent course date: _____ Reason: _____

OTHER SUBSTANCES – Which of the following have you used / do you currently use?

Substance	Past or Current	Dose / Amount	Date Started	Side Effects
Alcohol				
Caffeine				
Recreational Drugs				
Steroids				
Tobacco				
Other:				

REACTIONS TO VACCINATIONS (IF ANY)

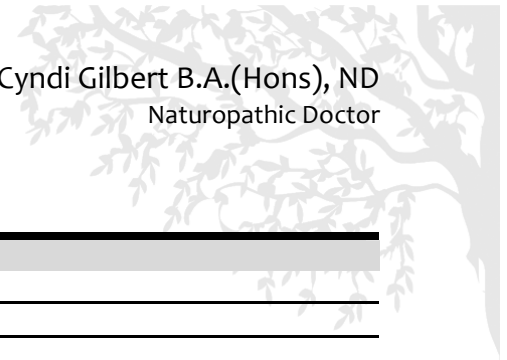
Type of Vaccine	Date(s)	Reaction / Side Effect

FAMILY HISTORY – Please ✓ if anyone in your immediate family (parents, siblings, grandparents, aunts/uncles) currently has or has had in the past any of the following:

If you do not have information about your biological family's medical history please skip the following

P=Past C=Current

	P	C	Family Member		P	C	Family Member
Alcoholism/Drug Abuse	<input type="checkbox"/>	<input type="checkbox"/>	_____	High Blood Pressure	<input type="checkbox"/>	<input type="checkbox"/>	_____
Allergies/Hay Fever	<input type="checkbox"/>	<input type="checkbox"/>	_____	Kidney Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Arthritis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Liver Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Asthma/Emphysema	<input type="checkbox"/>	<input type="checkbox"/>	_____	Mental Illness	<input type="checkbox"/>	<input type="checkbox"/>	_____
Breast Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Overweight/Obesity	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colon Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____	Prostate Cancer	<input type="checkbox"/>	<input type="checkbox"/>	_____
Colitis	<input type="checkbox"/>	<input type="checkbox"/>	_____	Skin Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Depression	<input type="checkbox"/>	<input type="checkbox"/>	_____	Thyroid disease	<input type="checkbox"/>	<input type="checkbox"/>	_____
Diabetes	<input type="checkbox"/>	<input type="checkbox"/>	_____	Stroke	<input type="checkbox"/>	<input type="checkbox"/>	_____
Heart Disease	<input type="checkbox"/>	<input type="checkbox"/>	_____	Other: _____	<input type="checkbox"/>	<input type="checkbox"/>	_____



Adult Intake Form

PERSONAL & CONTACT INFORMATION:

Name: _____ Address: _____
 Age: _____ Sex: _____
 Date of Birth: _____ Phone 1: _____
 Email: _____ Phone 2: _____

Emergency Contact: _____ Relationship: _____
 Phone 1: _____ Phone 2: _____

HOW DID YOU HEAR ABOUT CYNDI GILBERT, ND?

OTHER HEALTH CARE PROVIDERS – Please put a “*” beside the name of your primary health care provider

Name: _____ Specialty: _____ Phone: _____
 Name: _____ Specialty: _____ Phone: _____
 Name: _____ Specialty: _____ Phone: _____
 Date of last visit to medical doctor/health care provider? _____
 Date of last complete screening physical exam? _____

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR HEALTH IN ORDER OF IMPORTANCE?

1) _____
 2) _____ 4) _____
 3) _____ 5) _____

HOW WOULD YOU DESCRIBE YOUR GENERAL STATE OF HEALTH?

Excellent Good Fair Poor
 Comments: _____

MAJOR TRAUMAS / SURGERIES / INJURIES / ILLNESSES – Spiritual, mental, emotional, or physical

Incident	Date	Outcome

ALLERGIES AND SENSITIVITIES – List any known or suspected allergies, sensitivities and/or intolerances.

Substance (Food, Drug, Environmental / Chemical)	Reaction