ADULT INTAKE FORM

CYNDI GILBERT
NATUROPATHIC DOCTOR

PERSONAL & CONTACT INFORMATION

NAME: _____ ADDRESS: _____

GENDER: _____ ASSIGNED SEX: _____

PREFERRED PRONOUN: _____ PHONE: _____

DATE OF BIRTH (YY/MM/DD) _____ EMAIL: _____

EMERGENCY CONTACT: _____ PHONE: _____

HOW DID YOU HEAR ABOUT ME?

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

NAME: _____ SPECIALTY: _____ PHONE: _____

NAME: _____ SPECIALTY: _____ PHONE: _____

HOW WOULD YOU DESCRIBE YOUR GENERAL STATE OF HEALTH?

EXCELLENT ☐ GOOD ☐ FAIR ☐ POOR ☐

WHAT ARE YOUR TOP CONCERNS ABOUT YOUR HEALTH?

1) 2) 3)

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

EVENT	DATE	OUTCOME

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

SUBSTANCE (FOOD, DRUG, ENVIRONMENTAL / CHEMICAL)	REACTION

CURRENT MEDICATIONS & SUPPLEMENTS – *Please include all prescription drugs, over the counter drugs (aspirin, antacids, laxatives, ...), birth control pills, herbs, vitamins, minerals, homeopathics, etc. Feel free to email me pictures if that's easier.*

NAME	DOSE	REASON FOR TAKING	DATE STARTED	SIDE EFFECTS

166 Montrose Ave., Toronto ON, M6J 2T8 • **T:** 416.817.2385 **F:** 416.536.5063 • cyndi@cyndigilbert.ca • www.cyndigilbert.ca

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

	PAST OR CURRENT	AMOUNT	DATE STARTED	SIDE EFFECTS
ALCOHOL				
CAFFEINE				
RECREATIONAL DRUGS				
TOBACCO				

FAMILY HISTORY – *Please list if anyone in your biological family (parents, siblings, grandparents, aunts/uncles) has or has had any of the following. If you do not have information about your biological family's medical history, please skip.*

	FAMILY MEMBER		FAMILY MEMBER
ALCOHOLISM/DRUG ABUSE		DIGESTIVE CONDITION	
ALLERGIES/HAY FEVER		HEART DISEASE	
ARTHRITIS		MENTAL HEALTH CONDITION	
ASTHMA/EMPHYSEMA		OVERWEIGHT/OBESITY	
AUTO-IMMUNE CONDITION		SKIN DISEASE	
CANCER		THYROID DISEASE	
DIABETES		OTHER:	

SOCIAL HISTORY

SEXUALITY: _____ RELATIONSHIP(S): _____

HAPPY WITH YOUR SEX LIFE? _____ CHILDREN? _____

HOW WOULD YOU DESCRIBE THE EMOTIONAL CLIMATE OF YOUR HOME? _____

OCCUPATION: _____ DO YOU ENJOY YOUR WORK? _____

DIETARY RESTRICTIONS (E.G. RELIGIOUS, VEGETARIAN)? _____

DO YOU EXERCISE? IF YES, WHAT FORMS? _____ HOW OFTEN? _____

DIFFICULTY FALLING/STAYING ASLEEP? YES ☐ NO ☐ WAKE RESTED? YES ☐ NO ☐

ARE YOU CURRENTLY PREGNANT? ☐ ARE YOU CURRENTLY BREAST/CHEST FEEDING? ☐

LIFESTYLE

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 THAT YOU BELIEVE SUPPORT YOUR HEALTH?

WHAT BEHAVIOURS OR LIFESTYLE HABITS DO YOU CURRENTLY ENGAGE IN THAT YOU BELIEVE ARE SELF-HARMING?

WHAT POTENTIAL OBSTACLES DO YOU FORESEE IN ADDRESSING THE CAUSE(S) OF YOUR HEALTH CONCERNS AND RESTORING YOUR HEALTH?

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