Bayview North Family Chiropractic
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CONFIDENTIAL ADULT INTAKE FORM

DATE: ___________________________

PATIENT INFORMATION:

Full Name: ____

Date of Birth: MM / DD / YY Gender: _________________ Marital Status: _____________________________

Occupation: ________________________________ Employer: ____

Do you have extended health insurance coverage through your employer? ☐ Yes ☐ No ☐ Unsure

If yes, do your benefits cover naturopathic visits? ☐ Yes (Amount per year: $_________) ☐ No ☐ Unsure

How did you hear about our clinic? ______________________ Referred by: ______________________________

CONTACT INFORMATION:

Address: _______________________________________ Home Phone: __________________________________

____ Business Phone: _______________________________

____ Mobile Phone: _________________________________

____ E-mail Address: _______________________________

Preferred Contact: ☐ Home ☐ Business ☐ Mobile ☐ E-mail ☐ Other: ________________________________

EMERGENCY CONTACT INFORMATION:

Name: ____

Phone Number: __________________________________ Relationship: __________________________________

GENERAL HEALTH QUESTIONNAIRE:

Is this your first time seeing a Naturopathic Doctor? ☐ Yes ☐ No

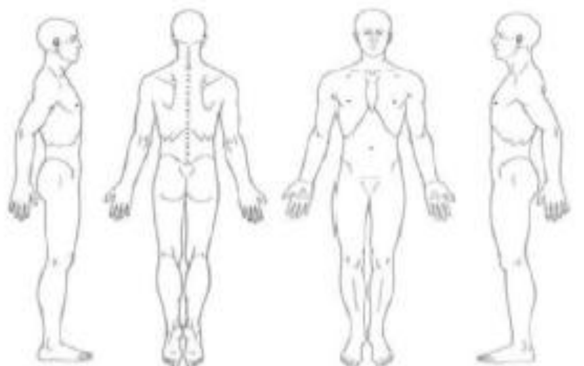
How would you describe your general state of health? ☐ Excellent ☐ Good ☐ Fair ☐ Poor

If you are female, are you currently pregnant or breastfeeding? ☐ Yes ☐ No

What are the health concerns that brought you to our clinic today? Please list them in order of importance to you along with an approximate date that the condition began.

Health Concerns	Date of Onset
1.	
2.	
3.	
4.	
5.	

If you are currently experiencing pain or other symptoms, please indicate where on the diagram below:



MEDICATIONS AND SUPPLEMENTS:

Please list all your current medications (prescription and over-the-counter) and supplements (vitamins, herbs, homeopathics, etc.):

Medication or Supplement	Dose, Frequency and Duration	Reason for Taking it

Do you frequently use any of the following?

☐ Pain Killers ☐ Laxatives ☐ Antacids ☐ Diet Pills ☐ Antibiotics

How many times have you been treated with antibiotics in the past 5 years? ___________________________

ALLERGIES AND SENSTIVITIES:

Please list all allergies and sensitivities that you experience (environmental, food, drugs, supplements, etc.):

Allergen	Reaction You Experience

PERSONAL AND FAMILY HEALTH HISTORY: ☐ I don't know my family medical history

Please indicate if you or a close relative currently has (or has had in the past) any of the following conditions:

Condition	Self	Father	Mother	Grandparent	Sibling	Child	Other Relative (Please Specify)
Allergies							
Asthma							
Heart Disease							
High Blood Pressure							
Stroke							
Cancer							
Diabetes							
Kidney Disease							
Osteoporosis							
Depression							
Other Mental Illness							
Substance Abuse							
Other Conditions: ____________________ ____________________							

COMPREHENSIVE HEALTH HISTORY:

Please indicate any major injuries, surgeries (including C-sections) and hospitalizations:

Major Injury/Surgery/Hospitalization	Approximate Date or Age

Childhood Illnesses:

☐ Measles ☐ Mumps ☐ Scarlet Fever ☐ Polio ☐ Chickenpox ☐ Colic

☐ Asthma ☐ Eczema ☐ Frequent Infections (Strep Throat, Ear Infections, Cold or Flu, etc.)

☐ Other: ____

Past Immunizations:

☐ Tuberculosis ☐ Tetanus booster ☐ Hepatitis A (Traveller's Vaccine)

☐ DPT (diphtheria, pertussis, tetanus) ☐ Smallpox ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Haemophilus influenza B

☐ "Flu" ☐ Other: ____

Did any of these cause an adverse reaction? Please explain: ______________________________________

____

OTHER HEALTH CARE PROVIDERS:

Please list all other health care providers that you are currently seeing or have seen in the past:

I am seeing/have seen a…	Date of Last Visit	Practitioner's Name and Contact Information
☐ Medical Doctor		
☐ Medical Specialist		
☐ Naturopathic Doctor		
☐ Chiropractor		
☐ Psychiatrist/Therapist/Counsellor		
☐ Optometrist		
☐ Dentist		
☐ Other:		
☐ Other:		
Approximate date of your last physical exam:		
Do you get regular screening tests done by another doctor (blood tests, PAP, etc.)? ☐ Yes ☐ No		

PERSONAL HEALTH HABITS:

Do you drink caffeinated beverages (tea, coffee, soft drinks, etc.)? ☐ Yes ☐ No

What type and how much per day? ______________________________

Do you drink alcohol? ☐ Yes ☐ No What type and how much per week? ______________________________

Do you smoke tobacco? ☐ Yes ☐ No What form and how much per day? ______________________________

Do you take recreational drugs? ☐ Yes ☐ No What type and how often? ______________________________

DIET:

Do you have any dietary restrictions (religious, vegetarian, vegan, gluten-free, etc.)?

____

____

Describe a typical day's diet:

Breakfast ______________________________

Lunch ______________________________

Dinner ______________________________

Snacks ______________________________

Beverages (and total quantity) ______________________________

EXERCISE:

How often do you exercise? ☐ 4-7 Times/week ☐ 2-3 Times/week ☐ Once a week ☐ Less than once a week

What do you do for exercise? How much and how often? ______________________________

____

____

ENVIRONMENT AND SAFETY:

Have you even been exposed to any known or suspected toxic substance as part of your job or otherwise (home, hobbies, etc.)? Please describe: ______________________________

____

How is your home heated? ______________________________

Are you exposed to significant tobacco smoke (at work or home, etc.)? ☐ Yes ☐ No

Are you frequently exposed to animals (pets, at work, etc.)? ☐ Yes ☐ No

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

____

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Thank you for taking the time to carefully fill out this extensive intake form.
If there is anything that you feel is important that has not been covered, please feel free to attach the information on a separate piece of paper. If available, please bring any copies of laboratory/imaging reports or any medical documentation to your first visit. I look forward to working with you!