**West Shore Family**
**NATUROPATHIC Ltd.**
office@westshorefamilynaturopathic.com

2885 Peatt Road
Langford, B.C. V9B 3V7
Phone: 250.474.6361

## Adult Intake

Name: _____ Date: _____
Address: _____
City: _____ Province: _____ Postal Code: _____
Telephone # (home):_____ (work): _____ (cell): _____
E-mail address: _____ Age: _____ Date of Birth: _____
Gender: Female_____ Male____ Education: _____
Married: ____Separated: _____ Divorced: _____ Widowed: _____ Single: ____ Partnership: _____
Live with: Spouse_____ Partner_____ Parents_____ Children (#)_____ Friends_____ Alone_____
Occupation: _____ Hours per week: _____ Retired: _____
Employer: _____
(Work address): _____
Referred by/How did you hear about our office? _____
_____
Has any other family member already been a patient at the clinic? _____
Next of Kin or other to reach in an emergency: _____
Relationship: _____ Phone: _____
Address: _____

**Do you have an active WCB claim? Y / N**
**Do you have an active ICBC claim? Y / N**

1. What expectation/goal(s) do you have for this visit?

   - What long-term expectations do you have from working with our office?

3) What is your present level of commitment to address any underlying causes of your signs and symptoms? (Rate from 0 to 10, with 10 being 100% committed – Please circle)

**0%** 0 1 2 3 4 5 6 7 8 9 10 **100%**

   - If below 8 what will it take to increase your level of commitment?

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

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

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**Other practitioners** you are currently seeing or have recently seen and treatments you are receiving.

Name Type of Practitioner Treatment

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

**Please list all surgeries/major procedures you've had:**

| Procedure | Year | Complications? |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |

**Please list your health concerns in order of importance:**

| Complaint | Since | Possible Cause(s) |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

**Do you have any known contagious diseases at this time? Y N If yes, please list?** _____

## Family History

Do you have a **family** history of any of the following? (Please tick all that apply)

☐Alcoholism ☐Allergies ☐Arthritis ☐Asthma ☐Cancer ☐Chronic bronchitis
☐Depression ☐Diabetes ☐Easy bruising ☐Eczema/skin diseases ☐Emphysema ☐Epilepsy
☐Gallstones ☐Glaucoma ☐Gout ☐Hay fever ☐Heart Disease ☐Hepatitis
☐Hypertension ☐Influenza ☐Kidney Disease ☐Mental Illness ☐Multiple sclerosis ☐Sexual Abuse
☐Osteoporosis ☐SickleCellAnemia ☐Rheumatic Fever ☐Stroke ☐Thyroid disease ☐Tuberculosis

Any other relevant family history? _____

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## Personal Medical History

Which of the following are relevant to **your** current/past medical history. (Please tick all that apply)

| | | | | | |
|---|---|---|---|---|---|
| ☐Abscesses | ☐Alcoholism | ☐Allergies | ☐Amnesia | ☐Arthritis | ☐Asthma |
| ☐Cancer | ☐Chicken pox | ☐Cold sores | ☐Depression | ☐Diabetes | ☐Diphtheria |
| ☐Emphysema | ☐Epilepsy | ☐Gallstones | ☐Gonorrhoea | ☐Gout | ☐Hay fever |
| ☐Heart Disease | ☐Hepatitis | ☐Herpes | ☐Anemia | ☐Hives | ☐Hypertension |
| ☐Influenza | ☐Kidney Disease | ☐Malaria | ☐Measles | ☐Mumps | ☐Mono/Epstein Barr |
| ☐Parasites | ☐Pneumonia | ☐Prostatitis | ☐Rheumatic Fever | ☐Rubella /German measles | ☐Scarlet fever |
| ☐Sexual Abuse | ☐Tuberculosis | ☐Thyroid | ☐Venereal warts | ☐Worms/Parasites | ☐Whooping cough |
| ☐Yellow fever | ☐Chlamydia | ☐ Stroke | ☐Freq Colds | ☐Mental Illness | ☐HIV |

Anything else not listed above?_____

## Current Medications

Please list everything you are currently taking (Prescription, over the counter, supplements, vitamins, minerals, natural health products)

| Medication/supplement | Since | Adverse Effects / Benefits |
|---|---|---|
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

## Allergies/Intolerances

Are you hypersensitive or allergic to...Any drugs? _____
Any foods? _____
Any environmental (pollens/pets) or chemical sensitivities? _____

## General

Height: _____Weight:_____ Weight 1 year ago: _____
Highest weight?_____When _____
When was the last time you had a physical exam? _____

### Males Only (P = significant past problem)

| | | | | | |
|---|---|---|---|---|---|
| Prostate disease? | Y | N | P | Testicular pain? | Y N P |
| Testicular masses? | Y | N | P | Discharge or sores? | Y N P |
| Are you sexually active? | Y | N | P | Birth control? | Y N |
| | | | | Type? _____ | |

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**Females Only**

(P = significant past problem)

Age of first menses? _____
Age of last menses? (if menopausal) _____
Length of cycle? _____ days
Duration of menses? _____ days
Date of last annual exam/ PAP _____
Abnormal PAP? Y N P
Are you sexually active? Y N P

Are cycles regular? Y N P
Bleeding between cycles? Y N P
Number of pregnancies: _____
Number of live births: _____
Number of miscarriages: _____
Number of abortions: _____
Birth control? Y N P
Type? _____

Is there anything else you would like to add that might be relevant to your health care?

**Thank you for your time and effort. We look forward to providing you with the best possible care.**