Adult Intake Form

CYNDI GILBERT
NATUROPATHIC DOCTOR

Personal & Contact Information:

Name: _____ Gender: _____
Pronouns: _____ Assigned sex: _____
Address: _____
Date of Birth (YY/MM/DD): _____ Phone: _____
Email: _____ Cell / work: _____

Emergency Contact: _____ Relationship: _____
Phone: _____ Cell / work: _____

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: _____
Date of last visit to medical doctor? _____

What are your top concerns about your health?

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

How would you describe your general state of health?

Excellent ☐ Good ☐ Fair ☐ Poor ☐
Comments: _____

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

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Phone: 416.817.2385 Fax: 416.536.5063
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Current Medications & Supplements – *Please include all prescription drugs, over the counter drugs (aspirin, antacids, laxatives, ...), birth control pills, herbs, vitamins, minerals, homeopathics, etc.*

Name	Dose	Reason for taking	Date Started	Side Effects

Other Substances – *Which of the following have you used / do you currently use?*

Substance	Past or Current	Amount	Date Started	Side Effects
Alcohol				
Caffeine				
Recreational Drugs				
Tobacco				

Family History – *Please list if anyone in your immediate biological family (parents, siblings, grandparents, aunts/uncles) currently has or has had any of the following:*

If you do not have information about your biological family's medical history please skip this section.

	Family Member		Family Member
Alcoholism/Drug Abuse	_____	High Blood Pressure	_____
Allergies/Hay Fever	_____	Kidney Disease	_____
Arthritis	_____	Liver Disease	_____
Asthma/Emphysema	_____	Mental Health	_____
Auto-Immune	_____	Skin Condition	_____
Cancer	_____	Thyroid disease	_____
Diabetes	_____	Stroke	_____
Heart Disease	_____	Other: _____	_____

Social History & Lifestyle

Sexual orientation: _____ Relationship(s): _____

Happy with your sex life? _____

Children? _____

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

Occupation: _____ Hours per week worked: _____

Do you enjoy your work? _____

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

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

Difficulty falling/staying asleep? _____ Wake rested? _____

What do you love to do? _____

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Social History & Lifestyle (cont'd)

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? _____

Diet and Metabolism– *Please recall what you ate yesterday*

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Drinks _____
Any food cravings? _____ Aversions? _____
Dietary restrictions (e.g. religious, vegetarian)? _____
Frequency of urination Per day: _____ Per night: _____
Frequency of bowel movements per day / week: _____

Reproductive & Sexual Health – *Please answer any questions that apply to you*

Age at menarche (1rst menses): _____ Age at menopause (if applicable): _____
Date of last menses: _____ # of pregnancies: _____ # of live births: _____
Currently pregnant? Y / N Currently breast/chest feeding? Y / N
History of breast/chest lumps, cysts, or masses? Y / N _____
History of testicular pain, lumps, cysts, or masses? Y/N _____
Regular PAP tests? Y / N Date of last PAP: _____
History of abnormal PAP(s)? Y / N If yes, date of abnormal PAP(s):
Challenges obtaining/maintaining erections and/or ejaculating? If yes, please explain.

Challenges with fertility? If yes, please explain.

Other concerns regarding your reproductive and/or sexual health?

This is to certify that I have answered the questions 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 _____

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