

Aqua Vitalis Naturopathic Clinic – Intake Form

(please print clearly)

Name: _____ **Date:** _____

Date of birth: (MM/DD/YY) _____

Gender: M F

Address: _____

Street Address

Apt #

City/Town

Postal Code

E-mail Address: _____

Telephone number: Home: () _____ **Work:** () _____

May we leave messages relating to your visits? Y / N

Emergency contact: Name: _____

Phone number: _____ **Relation:** _____

What are your health concerns, in order of their importance to you?

1. _____
2. _____
3. _____
4. _____
5. _____

Please list all current medications

(prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

How did you hear about our Clinic? _____

Referred by: _____

Women: Are you currently pregnant? Yes No

Medical history

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

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

Do you have any allergies (medicines, environmental, etc.)?

Please list past prescription medications, including the date started and discontinued.

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills / Implants / Injections

Alcohol—how much/day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please list all other health care providers you are seeing:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
(____)	(____)	(____)

When was your last visit to your MD? _____

What tests were done (eg- Pap, breast exam, lab tests) and what were the results?

Family history

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

✍ I don't know my family medical history

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (at work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? If so, please describe.

How would you describe the emotional climate of your home?

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

Diet

Do you have any food allergies or intolerances? Please list.

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

Is there anything that you feel is important to inform us of that has not been covered?

Thank you for taking the time to provide us with this valuable information.