LAURA DUGGAN, BSc, ND DOCTOR OF NATUROPATHIC MEDICINE
200 St Clair Ave West. Suite 411 Toronto, ON M4V 1R1
Tel: 647-478-4296 laura@arunahealth.com www.arunanaturalhealth.com

ADULT INTAKE FORM

Date (D/M/Y): ____/____/___

First Name:_____ Last Name:_____

Gender: M F Date of Birth (D/M/Y):____/____/____
Age:_____

Address: _____ Apt.: _____

City: _____ Province: _____ Postal Code:_____

Telephone #: Home (____) _____ Email: _____

Emergency Contact

1. Name:_____ Relation: _____ Tel.: (____) _____

2. Name:_____ Relation: _____ Tel.: (____) _____

Other Current Health Care Providers (Family Doctor, Chiropractors, Massage Therapists, etc.,)

1. Name:_____ Profession: _____ Tel.: (____) _____

2. Name:_____ Profession: _____ Tel.: (____) _____

Does your current extended health care plan cover visits to a naturopathic physician? Yes/ No / Unsure

How did you hear about us? _____
(Health care provider, friend, newspaper, phone book, etc.,)

List your primary health concerns

1._____ 2. _____

3._____ 4. _____

Have you had any serious illnesses, injuries or hospitalizations (include date):

_____

_____

Do you have any allergies (medication, environmental, food, pet):

_____

_____

If you are female, are you currently pregnant? Y/N Or trying to conceive? Y/N

Please list any current medications or supplements and doses:

_____

_____

_____

_____

Which toxins or chemicals are you regularly exposed to?

_____

Any recent vaccinations?

_____

How often do you exercise? ____days/week Type of exercise:_____

Current height? _____ Weight?_____ Is this a change for you? _____

What is your current energy level? (Please circle)

Low 1 2 3 4 5 6 7 8 9 10 High

What is your current stress level? (Please circle)

Low 1 2 3 4 5 6 7 8 9 10 High

What is/are your major source(s) of stress (circle all that apply):

work financial family partner relationships personal health spiritual other

Are you sexually active? (circle) Yes No Past

Method of contraception (condoms, birth control pill, IUD)_____

Sleep:

What time do you go to bed? _____ Wake up in the morning? _____

Do you wake feeling refreshed? Y / N

Do you have difficulty falling asleep? Y / N

Do you wake during the night? Y / N What wakes you?_____

Diet
Do you have any dietary restrictions?

_____

Please outline your diet during a typical day:
Breakfast:

_____

Lunch:

_____

Dinner:

_____

Snacks:

_____

How often do you consume the following: (indicate /day, /week or /month)

Water_____ Pop_____ Milk_____ Juice_____

Fresh vegetables/fruits_____ Cold-water fish_____ Tuna_____

Red meat_____ Chocolate_____ Processed food_____

Fast food_____ Canned goods_____ Microwavable meals_____

Do you use/have any of the following? Check off all that apply and indicate the frequency of use:

- ▫ Coffee _____
- ▫ Tea _____
- ▫ Alcohol _____
- ▫ Tobacco _____
- ▫ Recreational drugs _____
- ▫ Aspirin _____
- ▫ Tylenol _____
- ▫ Other pain meds _____
- ▫ Laxatives _____
- ▫ Diet pills _____
- ▫ Allergy meds _____
- ▫ Anti-acids_____
- ▫ Birth control pills
- ▫ Birth control implants (IUD)
- ▫ Birth control injections or patch
- ▫ Hormone replacement therapy
- ▫ Metal implants _____
- ▫ Mercury filings _____
- ▫ Resin filings _____
- ▫ Second hand smoke_____

Health Screening

Please check off which of the following tests you have had in the past 5 years, and indicate any significant results:

- ▫ CBC _____
- ▫ Cholesterol _____
- ▫ Blood sugar _____
- ▫ Thyroid _____
- ▫ Iron _____
- ▫ B12 _____
- ▫ Blood pressure _____
- ▫ Bone Density _____
- ▫ Colonoscopy _____
- ▫ STI testing _____

Women only:

- ▫ PAP smear_____
- ▫ Breast exam _____
- ▫ Mammogram _____

Men only:

- ▫ Digital rectal exam _____
- ▫ PSA _____

Family Health History:

Family Member	Health Concerns	Family Member	Health Concerns
Mother		Father	
Maternal grandmother		Paternal grandmother	
Maternal grandfather		Paternal grandfather	
Siblings		Children	

Other:

_____

_____

_____