Active Solutions Naturopathic Intake

(Please print clearly)

Name _____ **Date** _____

Date of birth _____/_____/_____ (M/D/Y) **Sex: M F**

Address_____

_____

E-mail Address _____

Home Phone Number _____ **Work** _____

Which Phone Number? _____

Occupation _____

Emergency contact: Name _____

Phone number _____ **Relation**_____

How did you hear about the Clinic? _____

Other Health Care Providers you are seeing:

Name	**1.** _____	**2.** _____	**3.** _____
Occupation	_____	_____	_____
Phone Number	**( )**_____	**( )**_____	**( )**_____
Location	_____	_____	_____

Please list your health concerns, in order of importance to you:

1. _____ **Since When?** _____

2. _____ **Since When?** _____

3. _____ **Since When?** _____

4. _____ **Since When?** _____

5. _____ **Since When?** _____

Please rate your general state of Health.

-3 -2 -1 0 1 2 3

Poor Fair Good Excellent

Medical History

Please list any serious conditions, illnesses, injuries and previous hospitalizations.

1. _____ When? _____

2. _____ When? _____

3. _____ When? _____

4. _____ When? _____

5. _____ When? _____

If you are female, are you currently pregnant? YES NO

Do you have any allergies, sensitivities or intolerances? (medicines, foods, environmental, etc.)

_____

_____

_____

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

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics). Please state the reason you are taking these medications.

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

How many times have you been treated with antibiotics? _____ Most recent date _____

How many root canal procedures have you had done? _____ Most recent date _____

Do you frequently use any of the following?

Aspirin / Tylenol /Advil / Aleve Antacids Birth Control Pills Laxatives Diet Pills

Alcohol (how much per day/week?) _____

Tobacco (form and quantity per day?) _____

Caffeine (form and quantity per day?) _____

Recreational Drugs (what and how often?) _____

What immunizations have you had? (circle)

DPT (diptheria, pertussis, tetanus)	**Haemophilus Influenza B**	**Hepatitis A**
Tetanus Booster	**"Flu"**	**Hepatits B**
MMR (measles, mumps, rubella)	**Polio**	**Smallpox**
Shingles	**Other**_____	

Have you ever had an adverse reaction to a vaccine? _____

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? YES NO

When was your full last physical? _____

Please indicate if a closer relative (parent, child, sibling) has had any of the following:

	Please indicate which family member
Allergies	
Asthma	
Autoimmune Condition (Please state which one(s))	
Heart Disease	
High Blood Pressure or High Cholesterol	
Cancer (Please state which one(s))	
Diabetes	
Depression and/or Anxiety	
Drug Abuse/ Alcoholism or Other Mental Illness	
Kidney Disease	
Other	

- ❑ **I don't know my family medical history**

How many days per week do you exercise? What do you do for exercise? How intense is the exercise you do (mild, moderate, intense)?

_____

_____

How would you rate the current stress in your life?

0 1 2 3 4 5

No stress Constant high stress

What factors contribute to your stress? _____

How do you manage your stress? _____

Do you have mold in your home? YES NO

Do you have a Carbon Monoxide detector in your home? YES NO

Are you frequently exposed to toxins or hazardous materials? (work, home, etc)

_____

Anything else?

_____

_____

_____

_____

_____