Dr. Anousha Usman, ND NATUROPATHIC ADULT INTAKE FORM

Please fill out the following form in as much detail as possible to help us best understand your needs and health concerns. All information shared is strictly confidential.

PATIENT INFORMATION		
Name:_____ (First) _____ (Middle) _____ (Last)		
Date of Birth: (mm/dd/yy)	Age:	Sex: ☐M ☐F ☐ Other_____
CONTACT INFORMATION		
Home Address:		
City:		Postal Code:
Home Phone:	Cell Phone:	Work Phone:
May we leave voicemails at the above phone numbers? If so, please select which ones. No confidential information is left on voicemails. ☐Home ☐Cell ☐Work		
Email address:		
Would you like to receive our newsletter for news, events and special offers? ☐Yes ☐No	Preferred method of contact: ☐Phone ☐Email	
EMERGENCY CONTACT INFORMATION		
Primary Contact:		
Relationship:		
Phone number(s) for emergency contact:		
OTHER HEALTHCARE PROVIDERS		
Medical Doctor:	Location and phone number:	Date of last visit:
Other Practitioner/Specialist:	Location and phone number:	Date of last visit:
Other Practitioner/Specialist	Location and phone number:	Date of last visit:

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CLINIC INFORMATION

How did you hear about the clinic?

Were you referred to Dr. Anousha? If so, who referred you?

Have you been to a naturopathic doctor before? ☐Yes ☐No

HEALTH CONCERNS

What are your most important health concerns? Please list them in order of importance

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

Do you have any known contagious diseases at this time? ☐Yes ☐No
If yes, please provide details.

MEDICATION AND SUPPLEMENTS

Please list any prescription medications, over the counter medications, vitamins, or other supplements you are taking **with dosages and frequency:**

	Dose	**Frequency**
1. _____		
2. _____		
3. _____		
4. _____		
5. _____		
6. _____		
7. _____		
8. _____		
9. _____		

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ALLERGIES & SENSITIVITIES (PLEASE LIST)

_____ _____ _____

_____ _____ _____

_____ _____ _____

CONTEXT OF CARE

What 3 health goals do you have while under the care of Dr. Anousha?

1. _____
2. _____
3. _____

GENERAL INFORMATION

Height: _____ Weight:_____ Weight one year ago: _____	Please indicate level of satisfaction on a scale of 0-10, 10 being the most satisfied Sleep Energy Mood	Do you perform any regular physical exercise? ☐ Yes ☐ No If so, how many hours?	Indicate how many hours you sleep each night: Do you wake feeling rested: ☐Yes ☐No

FAMILY HISTORY

Family Member	Age	Illness
1. _____	_____	_____
2. _____	_____	_____
3. _____	_____	_____
4. _____	_____	_____
5. _____	_____	_____
6. _____	_____	_____

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REVIEW OF SYMPTOMS		
Do you now, or have you in the past, experienced any of the following symptoms? Please check (√) any that apply.		
☐ Fever ☐ Chills **Skin:** ☐Rash ☐Eczema, hives ☐Acne, boils ☐Itching ☐Colour change ☐Lumps ☐Night sweats ☐Dryness/moistness ☐Temperature change ☐Nail change ☐Changes in mole ☐Skin cancer **Head:** ☐Headache ☐Head injury ☐Dizziness **Ears:** ☐Impaired hearing ☐Earache ☐Dizziness ☐Discharge ☐Infections	**Eyes:** ☐Impaired vision ☐Glasses/contacts ☐Tearing or dryness ☐Double vision ☐Glaucoma ☐Cataracts ☐Blurring ☐Bothered by sun ☐Itching ☐Redness ☐Discharge ☐Blind spot **Nose and Sinuses:** ☐Frequent colds ☐Nose bleeds ☐Stuffiness ☐Hay fever ☐Sinus problems **Mouth and Throat:** ☐Frequent sore throat ☐Sore tongue/mouth ☐Gum problems ☐Hoarseness ☐Dental cavities ☐Loss of taste	**Neck:** ☐Lumps ☐Swollen glands ☐Goiter ☐Pain of stiffness **Respiratory:** ☐Cough ☐Sputum ☐Spitting up blood ☐Wheezing ☐Asthma ☐Bronchitis ☐Pneumonia ☐Emphysema ☐Difficulty breathing ☐Pain on breathing ☐Shortness of breath ☐Shortness of breath at night ☐Shortness of breath lying down ☐Tuberculosis ☐Tuberculin test **Breasts:** ☐Do you do self exams? ☐Lumps ☐Pain (or tenderness) ☐Nipple discharge

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Gastrointestinal:

☐Trouble swallowing

☐Heartburn

☐Change in thirst

☐Change in appetite

☐Nausea

☐Vomiting

☐Vomiting blood

☐Bowel movements (how often?)

_____

☐Blood in stool

☐Belching or passing gas

☐Jaundice (yellow skin)

☐Liver disease

☐Gall bladder disease

☐Ulcer indigestion

☐Constipation

☐Diarrhea

☐Rectal bleeding

☐Hemorrhoids

☐Black, tarry stool

☐Abdominal pain

☐Food allergy

☐Hernias

Cardiovascular:

☐Heart disease

☐Angina

☐High blood pressure

☐Murmurs

☐Rheumatic fever

☐Chest pain

☐Swelling in ankles

☐Palpitations, fluttering

☐Cyanosis

☐Past ECG

☐Other heart tests

Peripheral Vascular:

☐Deep leg pain

☐Cold hands/feet

☐Varicose veins

☐Thrombophlebitis

☐Leg cramps

☐Extremity numbness

☐Extremity coldness

☐Extremity swelling

☐Extremity ulcers

Blood/Lymphatic:

☐Anemia

☐Easy bleeding or bruising

☐Past transfusions

☐Lymph node swelling

Neurologic:

☐Fainting

☐Seizures/convulsions

☐Paralysis

☐Muscle weakness

☐Numbness or tingling

☐Loss of memory

☐Involuntary movement

☐Loss of balance

☐Speech problems

Musculoskeletal:

☐Joint pain of stiffness

☐Arthritis

☐Broken bones

☐Muscle spasms or cramps

☐Weakness

☐Joint swelling

☐Backache

Urinary:

☐Pain on urination

☐Increased frequency

☐Frequency at night

☐Inability to hold urine

☐Frequent infections

☐Kidney stones

☐Blood in urine

☐Urgency

☐Hesitancy

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Male Reproductive:	**Female Reproductive:**	**Female continued**
☐Hernias	Age menses began:	Sexually active ☐Yes ☐No
☐Testicular masses	_____	☐Sexual difficulties
☐Testicular pain	Average number of days:	Last menstrual period:
Sexually active ☐Yes ☐No	_____	_____
☐Sexual difficulties	Length of cycle:	☐Vaginal discharge
☐Venereal disease	_____	☐Vaginal itching
☐Discharge or sores	Are cycles regular ☐Yes ☐No	Last PAP (date):
Endocrine:	☐Pain during intercourse	_____
☐Heat of cold intolerance	☐Painful menses	
☐Thyroid trouble	☐Excessive flow	**Emotional:**
☐Excessive thirst	☐PMS	☐Depression
☐Excessive hunger	Birth control ☐Yes ☐No	☐Mood swings
☐Excessive urination	Type:_____	☐Anxiety or nervousness
☐Excessive sweating	Number of pregnancies:	☐Tension
☐Diabetes	_____	☐Phobias
☐Hypoglycemia	Number of live births:	☐Alcohol/drug abuse
☐Hormone therapy	_____	Treated? ☐Yes ☐No
	Number of miscarriages:	☐Insomnia
	_____	
	Number of abortions:	
	_____	
	Difficulty conceiving ☐Yes ☐No	