LINDSAY MARTENS, N.D.
Doctor of Naturopathic Medicine

Confidential Patient Intake Form

Name:______________________________ Today's Date:________________

Age:________ Date of Birth: ____________ Gender: ◇ M ◇ F

Address: ____________________________ City: ________________

Province: ________________ Postal Code:____________________

Home Phone: ______________ Work or Other Phone: ______________

Profession: ______________ Employer: ____________________

E-mail Address: ______________________________________

Other Health Care Providers (name and phone number):

1. ____________________________________Phone:________________

2. ____________________________________Phone:________________

3. ____________________________________Phone:________________

Do you have extended medical insurance?______________________________

Person to notify in emergency?__________________Relationship:______________

Phone:______________

How did you hear about this clinic?______________________________

Current Health Status

What health concerns brought you in today? Please list in order of importance to you.

1. ____
2. ____
3. ____
4. ____
5. ____

Has anything recently changed or become worse? ______________________________

____

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Please list the three most significant stressful events in you life. Are any of these still continuing to affect you?

1. ____________________

2. ____________________

3.____________________

Personal Health Habits

Height:__________ Current Weight: __________Weight 1 year ago: __________

Maximum weight: __________ When? __________

Smoker: ◇Yes ◇ No How many years? __________ Amount/day:__________

Year Stopped: __________

Alcohol use: ◇Yes ◇ No Type: __________Frequency: __________

Recreational Drug Use: ◇Yes ◇ No Type: __________Frequency: __________

Coffee: ◇ Yes ◇ No ________cups/day Tea: ◇ Yes ◇ No ________cups/day

Water: ______cups/day

List foods eaten on a typical day and the average time that you eat:

Breakfast: ____________________Time: __________

Lunch: ____________________Time: __________

Dinner: ____________________Time: __________

Snacks: ____________________Time: __________

On a scale of 1 to 10, with 10 being the highest, rate your average stress level: __________

On a scale of 1 to 10, with 10 being the highest, rate your average energy level: __________

How many hours of sleep do you get a night? __________Do you wake feeling rested? ◇ Yes ◇ No

Do you get regular exercise? ◇Yes ◇ No Type: __________Duration: __________

Frequency: __________

Is there anything that you do on a daily basis to relieve stress? __________

____

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Medical History – Please indicate the conditions which affect you

- Alcohol Abuse
- Allergies
- Anemia
- Arthritis
- Asthma
- Bladder/Urinary problems
- Bleeding problems
- Blood pressure problems/Stroke
- Cancer
- Colitis
- Frequent colds, flu, sore throats
- Diabetes
- Digestive problems
- Ear problems
- Eating disorders
- Edema
- Epilepsy
- Eye problems
- Fatigue, chronic
- Female gynecological problems
- Mononucleosis
- Fever
- Liver/Gallbladder problems
- Gum/Teeth problems
- Hay Fever
- Headaches
- Head Injury/Serious Injury
- Heart Disorders
- Hepatitis
- Hypoglycemia
- Jaundice
- Joint problems
- Kidney problems
- Lung problems
- Occupational exposure to toxic substances
- Parasites
- Psychological difficulties/suicidal/ depression
- Sexually Transmitted Infections
- Skin problems
- Thyroid concerns
- Ulcer

Please indicate any serious injuries or hospitalizations along with approximate dates:

____

____

Do you have any allergies?____

____

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Check any of the following that you currently use, and indicate how often you used them or how long you have been using them for:

☐ Laxatives ___________ ☐ Birth Control Pills ________ ☐ Sleeping Pills _____________

☐ Cortisone _________ ☐ Pain Relievers ___________________ ☐ Aspirin ___________

☐ Antacids __________ ☐ Anti-Depressives _________

Please list all drugs and medications which you are currently prescribed, the reason and for how long:

1. ____How long? ________________________

2. ____How long? ________________________

3. ____How long? ________________________

4. ____How long? ________________________

5. ____How long?________________________

Please list all supplements or botanical medicines that you are currently using, the reason and for how long:

1. ____How long? ________________________

2. ____How long? ________________________

3. ____How long? ________________________

4. ____How long? ________________________

5. ____How long? ________________________

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Family History – Has a close relative (parent, child, sibling, grandparent) had any of the following?

	Who?		Who?
Allergies		Depression	
Arthritis		Other mental illness	
Asthma		Drug abuse/alcoholism	
Epilepsy		Bleeding problems	
Heart disease		Multiple sclerosis	
High blood pressure		Kidney disease	
Stroke		Tuberculosis	
Cancer		Thyroid problems	
Diabetes		Other	

Environment

Are you regularly exposed to toxins or other hazards (home, work, hobbies, etc.)? Please describe:

____

____

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

____

How would you describe the emotional climate of your work? ____________________

____

Personal Health History

Were you breast fed and for how long? ________________________________

What was your like health as a child? ________________________________

____

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Did you have any childhood illnesses? ____

____

Please list all surgeries that you have had and there dates:

1. ____Date: _________________

2. ____Date: _________________

3. ____Date: _________________

Have you ever had a parasite that you know of? ____________________________________

Have you ever traveled to a third world country? _____________ If so, for how long? _______

What do you feel is your weakest organ system? ____________________________________

How many times a year do you get a cold, flu, or bronchitis? __________________________

How many days are you sick for? ________ Do you miss work because of it? ______________

How many times in your life have you been treated with antibiotics? ___________________

Have you ever taken probiotics following a round of antibiotics? _______________________

Has there been a trauma or illness that you have never recovered from and you have not been well since? ____

____

Health Goals

Please list your health goals in order of importance to you:

1. ____

2. ____

3. ____

4. ____

5. ____

Thank you for taking the time to complete this intake form.

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