



**Adult Intake Form**

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**Adult Intake Form**

Name \_\_\_\_\_ Date of 1<sup>st</sup> Visit \_\_\_\_\_

Date of Birth (y/m/d) \_\_\_\_\_ Age \_\_\_\_\_

Address \_\_\_\_\_

City \_\_\_\_\_ Province \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (home) \_\_\_\_\_ Work and/or Cell \_\_\_\_\_

Can messages be left at: Home Y/N Work/Cell: Y/N

Email \_\_\_\_\_ Employer \_\_\_\_\_

Occupation \_\_\_\_\_ Hrs/wk \_\_\_\_\_

Marital Status \_\_\_\_\_ Children \_\_\_\_\_ Ages \_\_\_\_\_

**Emergency Contact**

Name \_\_\_\_\_ Phone \_\_\_\_\_

Relationship \_\_\_\_\_ Address \_\_\_\_\_

How did you hear about the clinic? \_\_\_\_\_

Have you received Naturopathic care previously? \_\_\_\_\_

**Other Health Care Providers**

1. \_\_\_\_\_ ( ) \_\_\_\_\_

2. \_\_\_\_\_ ( ) \_\_\_\_\_

3. \_\_\_\_\_ ( ) \_\_\_\_\_

**List Primary Health Concerns (in order of importance)**

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

**Health History**

Are you currently being treated for a health concern by other health care practitioners?

Explain \_\_\_\_\_

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

Date of last physical exam \_\_\_\_\_ Most recent lab/blood work \_\_\_\_\_

List any serious illnesses, hospitalizations, surgeries. X-rays, imaging or blood work with approximate date

\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_  
\_\_\_\_\_ Date \_\_\_\_\_

List all prescription medications and over the counter medications you currently take:

\_\_\_\_\_ Dosage \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_

List all vitamins, minerals, herbs or any natural health product you currently take:

\_\_\_\_\_ Dosage \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_  
\_\_\_\_\_ Dosage \_\_\_\_\_

List any past prescriptions medications

\_\_\_\_\_  
\_\_\_\_\_

**Allergies**

Are you sensitive or allergic to?

Any foods? \_\_\_\_\_

Any drugs? \_\_\_\_\_

Any supplements? \_\_\_\_\_

Any chemical or environmental? \_\_\_\_\_

**Personal Overview**

What do you know about the Naturopathic approach? \_\_\_\_\_

What expectations do you have from this visit? \_\_\_\_\_

What long term expectations do you have with working with this clinic \_\_\_\_\_

What expectations do you have of me personally as your physician? \_\_\_\_\_

What is your present level of commitment to making changes in your health? Please circle (10 = 100% committed)

1    2    3    4    5    6    7    8    9    10

What behaviors or lifestyle habits to you currently engage in regularly that you believe support your health? \_\_\_\_\_

\_\_\_\_\_

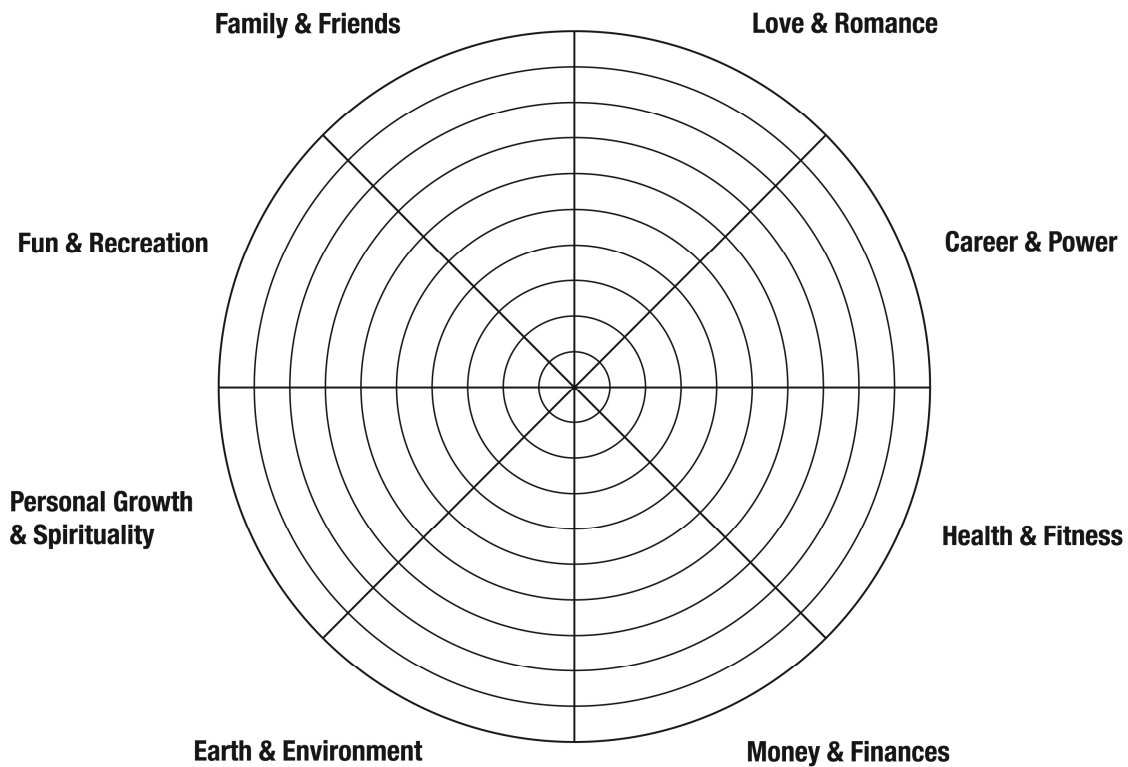
What behaviors or lifestyle habits do you currently engage in regularly that you believe are self-destructive to your health? \_\_\_\_\_

What potential obstacles do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you? \_\_\_\_\_

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making? \_\_\_\_\_

What do you LOVE to do? \_\_\_\_\_

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.  
For example, if you are extremely happy in your career, shade the entire pie shape for career  
Do the same for each area, starting from the centre point radiating outwards



**Lifestyle & Environment**

Hobbies & Interests \_\_\_\_\_

Do you exercise? \_\_\_\_\_

If you do exercise what form of exercise, how frequent, how long?

\_\_\_\_\_

Are you exposed to toxins or other hazards (work, home, hobbies) please list.

\_\_\_\_\_

How would you describe the emotional climate of your home?

\_\_\_\_\_

Is there anything else you would like to add or comment on? \_\_\_\_\_

\_\_\_\_\_

**Thank you for your time.**

**I look forward to working with you!**