intuition wellness center
LEARN. GROW. THRIVE.

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intuitionwellness.com

Intake - Adult

Naturopathic Medicine

Date: _____

Patient Name: _____ ***Date of Birth:*** _____

Occupation: _____ **Hours per week:** _____

Martial Status: ☐ Married ☐ Separated ☐ Divorced ☐ Widowed ☐ Single ☐ Partnership

Live With: ☐ Spouse ☐ Partner ☐ Parents ☐ Children ☐ Friends ☐ Alone

☐ Other: _____

Current Providers

Family Physician: _____

Name Phone

Counselor/Therapist: _____

Name Phone

Psychiatrist: _____

Name Phone

Additional Providers: (name and phone)

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

What are your main health concerns, in order of importance to you?

1. _____
2. _____
3. _____
4. _____

Additional health concerns:

Medical History

Date of last physical exam: _____ Current Height: _____ Weight: _____

Maximum Weight: _____ When? _____ Energy Level: (1-10; 10 highest) _____

Are you hypersensitive or allergic to any:

- ☐ Drugs: _____
- ☐ Foods: _____
- ☐ Environment/Chemicals: _____

How would you describe your general health? ☐ Poor ☐ Fair ☐ Good ☐ Excellent

Do you smoke or use tobacco products? _____ times/day Other: _____

How often do you drink alcohol? _____ times/week Other: _____

Additional treatments or healthcare: (e.g., physiotherapy, massage, chiropractic, etc.)

Please indicate any serious conditions, illnesses, surgeries, and hospitalizations with approximate dates:

Do you receive regular screening tests performed by another doctor? (e.g., pap, blood tests, etc.)

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

Which medications, either by prescription or over-the-counter, are you currently taking or have taken over the past six months?

☐ Laxatives	☐ Antidepressants	☐ Cholesterol-lowering medication
☐ Pain Relievers	☐ Antibiotics	☐ Ulcer medication
☐ Sleeping Meds	☐ Sedatives	☐ Birth Control Pills
☐ Antacids	☐ Thyroid Medication	☐ Hormone Replacement
☐ Cortsone/Prednisone	☐ Antidepressants	

Please list, by name, any prescription medications you currently take, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dosage, if known.

Note: Please bring each of these with you to your first office visit.

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

Other:

Family History

Do you have a family history of any of the following diseases or conditions? If known, please include your parents, siblings and grandparents.

☐ Anemia	☐ Arthritis	☐ Asthma
☐ Cancer	☐ Diabetes	☐ Epilepsy
☐ Heart Disease	☐ Hypertension	☐ Kidney Disease
☐ Mental Illness	☐ Multiple Sclerosis	☐ Parkinson's
☐ Alzheimer's	☐ Stroke	

Please list other significant family medical history not listed above:

Is there any information about your health that you would like to add?

Thank you for choosing Intuition Wellness Center to assist you and your family to live in health and joy!