PRECISIONHEALTH

Naturopathic Intake Form

Dr. Nadia Lamanna ND., HBSc.

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future please let us know. All information gathered for treatments is confidential except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name: _____ Age: _____ DOB: _____ Gender: _____

Address: _____
Number Street Suite City Province Postal Code

Tel (home): ( )_____ Tel (work): ( )_____ Cell: ( ) _____

Occupation: _____ Email: _____

Marital Status: ❑Single ❑Married ❑Divorced ❑Widow ❑Common Law ❑Separated Children: _____

Physician's Name: _____ Tel: ( ) _____

Physician's Address: _____
Number Street Suite City Province Postal Code

If Emergency Notify: _____ Relationship: _____ Tel: ( ) _____

Date of last visit to physician or health practitioner: _____

How did you hear about us? _____

Major complaints in order of importance to you:

Complaint	Since	Causes
1		
2		
3		
4		
5		

Have you ever seen a naturopathic physician, chiropractor, acupuncturist or other alternative health practitioner for any of your problems? ❑ No ❑ Yes

What was the therapy and result?

_____

What operations have you had?

Operation	When	Complications

What major injuries have you had?

Injury	When	Long Term Effects

GOALS: What would you like to achieve through your visits at Precision Health & Wellness, in order of importance to you?

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

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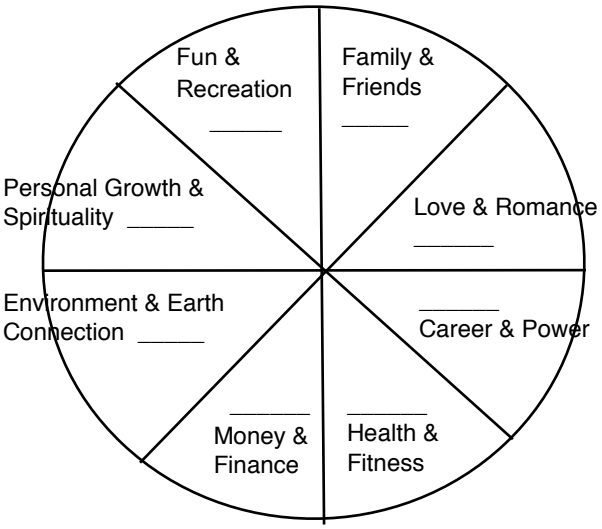
Please indicate on the pie chart your level of personal satisfaction in the following areas of your life by assigning a number from 0-10 in each area
(10 = very satisfied)



What is the general state of your health?

- ❑ Excellent
- ❑ Good
- ❑ Average
- ❑ Fair
- ❑ Poor

Please list the 5 most significant and stressful events in your life (from most recent)

1. _____
4. _____
5. _____
6. _____
7. _____

Are any of these situations continuing to impact your life? ❑ No ❑ Yes

Are you currently working with a professional counsellor, psychologist, social worker or other therapist? Please specify.

_____

Have you in the past? ❑ No ❑ Yes If so, when? _____

Medications & Supplements

Drug, Vitamin or Herb Name	Dosage	Duration

Which of the following conditions have you had?

alcoholism		depression		gout		miscarriage		rubella		tonsillitis	
allergies		diptheria		heart disease		mononucleosis		scarlet fever		tuberculosis	
anemia		diabetes		hepatitis		mumps		sexual abuse		typhoid fever	
arthritis		ear infections		herpes		parasites		skin disease		UTI	
asthma		emphysema		insomnia		PID		strep throat		venereal warts	
BPH		epilepsy		kidney stones		pleurisy		sinusitis		warts	
cancer		gall stones		leukaemia		pneumonia		stroke		weight problem	
chicken pox		goitre		malaria		prostatitis		syphilis		whooping cough	
cold sores		gonorrhoea		measles		rheumatic		thyroid problem		yellow fever	

Any illnesses not listed? Please specify: _____

Any allergies to drugs, herbs, foods, animals, other? ❑ No ❑ Yes If yes, please list:

_____

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Review of Systems

Please circle if you are currently experiencing (“C”) or have experienced in the past (“P”)

General

P C Headaches
P C Migraines
P C Fatigue
P C Fever
P C Sweats
P C Heat or cold intolerance
P C Dizziness
P C Fainting
P C Poor/Disturbed sleep
P C Weight change
P C Numbness/Tingling
P C Allergies
P C Seizures

Gastrointestinal

P C Constipation
P C Diarrhea
P C Abdominal bloating
P C Abdominal pain
P C Gas
P C Heartburn
P C Undigested food in stool
P C Blood in stool
P C Belching
P C Change in appetite
P C Nausea/vomiting
P C Colitis
P C Crohn’s
P C IBS
P C Celiac
P C Hemorrhoids
P C Hernia

Respiratory

P C Asthma
P C Emphysema
P C Persistent cough
P C Chronic bronchitis
P C Shortness of breath
P C Excess phlegm
P C Spitting up blood
P C Smoker

Eyes, Ears, Nose, Throat

P C Ear infections
P C Ringing in the ears
P C Deafness
P C Vertigo
P C Ear discharge
P C Eye pain
P C Eye infections
P C Failing vision
P C Glaucoma
P C Cataracts
P C Mercury tooth fillings
P C Gum disease
P C Frequent colds/flu
P C Recurrent strep throat
P C Sinus infection
P C Sore throat
P C Hoarseness
P C Cold sores
P C History of head injury

Skin

P C Hives/allergy
P C Acne
P C Ezcema
P C Psoriasis
P C Bruises easily
P C Hair loss
P C Warts
P C Change of mole
P C Skin dryness
P C Fungal infections

Musculoskeletal

P C Muscle pain
P C Muscle weakness
P C Muscle spasm/cramp
P C Jaw pain
P C Spinal curvature
P C Arthritis
P C Osteoporosis
P C Bursitis
P C Tendonitis
P C Gout

Cardiovascular

P C Palpitations
P C Murmurs
P C High cholesterol
P C High blood pressure
P C Previous Heart attack
P C Heart disease
P C Varicose veins
P C Ankle swelling
P C Poor circulation
P C Cold hands/feet
P C Shortness of breath
P C Chest pain/angina
P C Anemia

Kidney & Reproductive

P C Inability to control urine
P C Frequent urination
P C Wake up to urinate
P C Urinary tract infection
P C Painful urination
P C Blood in urine
P C Kidney infection
P C Kidney stones
P C Genital warts/sores
P C PMS
P C Menopause
P C Endometriosis
P C Hysterectomy
P C STD’s
P C Pregnancy
P C Prostatitis/ BPH

Emotional

P C Depression
P C Anxiety
P C Mood swings
P C Anger
P C Eating disorder
P C Phobia
P C Drug abuse
P C Thoughts of suicide
P C Psychiatric issues
P C Counseling

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Which of the following do you currently use? Please indicate how much, how often, how long:

alcohol _____ hormones _____
coffee _____ sedatives _____
tobacco _____ laxatives _____
antacids _____ cortisone _____
artificial sweeteners_____ recreational drugs _____

Age of first menses: _____ Age at menopause: _____ Number of pregnancies: _____ Number of births: _____

How many times have you been treated with antibiotics? _____
For what conditions? _____

Do you exercise? ❑ No ❑ Yes If yes, what type and how often? _____

Describe, on average your energy level on a scale from 1-10 (10= the highest) _____
During the day when is your energy level the best?/ the worst? _____

Family History

Please list any genetic disorders, mental and/or physical health problems:

	living age	health problems	age and cause of death
Mother			
Father			
Siblings			
Maternal Gr.Mom			
Maternal Gr.Dad			
Paternal Gr. Mom			
Paternal Gr. Dad			
Maternal aunt(s)			
Maternal uncle(s)			
Paternal aunt(s)			
Paternal uncle(s)			

Vaccinations

	Age	Reaction
DPT (diptheria, pertussis, tetanus)		
Polio (IPV, DPTP)		
MMR (measles, mumps, rubella)		
Flu		
Hep B		
Gardasil (HPV)		
Others _____		

Do you have a history of exposure to toxic substances? ❑ No ❑ Yes. If yes, please list:

_____

Is there any additional information you would like to add?

_____
_____
_____

Signature _____ Date _____

Thank you for taking the time to complete this form. All information is confidential and will not be released for legal or medical purposes without your consent.