Live Well Osteopathy & Massage Therapy
Karen Maloney-Younker ND

Adult Intake Form

Name: _____ Date: _____

Date of Birth: _____ (Month/Day/Year)

Address: _____ Apt/Unit #: _____

City: _____ Province: _____ Postal Code: _____

Email Address: _____

Telephone Number: Home: _____ Work: _____ Cell: _____

Preferred number at which to be contacted _____

Emergency contact: Name: _____

Phone number: _____ or _____ Relation: _____

Other health care providers you are seeing (MD, osteopath, etc):

Name: _____ Name: _____ Name: _____

Specialty: _____ Specialty: _____ Specialty: _____

Phone #: _____ Phone #: _____ Phone #: _____

Date of last visit: _____ Date of last visit: _____ Date of last visit: _____

Have you previously consulted with a Naturopathic Doctor? _____

What are your health concerns/goals?

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

Are you currently pregnant? Yes/No (please circle one) Due Date: _____
Are you currently lactating? Yes/No (please circle one)

Medical History

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers Y N P
Laxatives Y N P
Antacids Y N P
Diet pills Y N P
Birth control Y N P Type (please circle) Pills / Implants / Injections
Antibiotics Y N P Approximate number of prescriptions: _____
Medications----which drugs and dosage
_____
_____
_____
Supplements---which ones and what dosage
_____
_____
_____
Alcohol—how much/day or week _____
Tobacco—form and amount/day _____
Caffeine—form and amount/day _____
Recreational drugs—what and how often_____

Please indicate what immunizations you have had (circle):

DPT (diphtheria, pertussis, tetanus) Tetanus booster; when? _____

Haemophilus influenza B(Hib) Hepatitis A Flu Hepatitis B Meningicoccal

MMR (measles, mumps, rubella) Polio Smallpox Pneumococcal

Other _____

Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Last time you had blood work done_____

Diet

Do you have any food allergies or intolerances? Please list.
_____
_____
_____

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

_____

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all whom the condition applies to: "Self" if it relates to you and/or Father (F), mother (M), sibling (S), Grandparent (G), your child (C). Please circle Past if the condition is resolved, or Current if it is on-going and current

	Yes	Relation (Please circle)	Date		Yes	Relation (Please circle)	Date
Alcoholism/ Drug Addiction		Self F M S G C	Past /Current	High Blood Pressure		Self F M S G C	Past /Current
Allergies		Self F M S G C	Past /Current	Heart Disease		Self F M S G C	Past /Current
Anemia		Self F M S G C	Past /Current	Hepatitis		Self F M S G C	Past /Current
Arthritis		Self F M S G C	Past /Current	Headaches		Self F M S G C	Past /Current
Asthma		Self F M S G C	Past /Current	Osteoporosis		Self F M S G C	Past /Current
Cancer		Self F M S G C	Past /Current	Kidney Disease		Self F M S G C	Past /Current
Diabetes		Self F M S G C	Past /Current	Stroke		Self F M S G C	Past /Current
Eczema		Self F M S G C	Past /Current	Tuberculosis		Self F M S G C	Past /Current
Epilepsy		Self F M S G C	Past /Current			Self F M S G C	Past /Current
Depression/ Mental Illness		Self F M S G C	Past /Current	Others:		Self F M S G C	Past /Current

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N
What do you do for exercise, how much, how often?
_____
_____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?_____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____
_____
_____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____
_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____
_____