Thornhill Naturopathic HEALTH CLINIC

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WALK IN or ACUTE INTAKE FORM

Patient's name: _____

Date: _____

Please list your chief complaint(s): _____

Check the conditions that you are currently experiencing, or have experienced often in the past. If more space is required please use the reverse side of this sheet.

General Symptoms

	current	previous
Loss of consciousness	☐	☐
Numbness / tingling	☐	☐
Fever	☐	☐
Sweats	☐	☐
Fainting	☐	☐
Dizziness	☐	☐
Loss of sleep/insomnia	☐	☐
Frequent colds / flus	☐	☐
Loss of weight	☐	☐

Head / Neck

Headaches	☐	☐
Type _____		
Vision problems	☐	☐
TMJ concerns	☐	☐
Earaches	☐	☐
Decreased hearing	☐	☐
Sinus problems	☐	☐
Difficulty swallowing	☐	☐

Skin

Rashes / Eczema	☐	☐
Itching	☐	☐
Bruise easily	☐	☐
Dryness	☐	☐
Boils / Hives	☐	☐
Contagious skin disease	☐	☐

Respiratory

Chronic cough	☐	☐
Shortness of breath	☐	☐
Smoking	☐	☐
Breathing problems	☐	☐
Asthma / Bronchitis	☐	☐

Do you exercise? Yes ☐ No ☐

Cardiovascular

	current	previous
High blood pressure	☐	☐
Low blood pressure	☐	☐
Bleeding disorders	☐	☐
Chest pain	☐	☐
Stroke	☐	☐
Artery hardening	☐	☐
Varicose veins	☐	☐
Swelling of the ankles	☐	☐
Poor circulation	☐	☐
Angina	☐	☐
Heart disease	☐	☐

Genitourinary

Trouble urinating	☐	☐
Blood in the urine	☐	☐
Kidney infections	☐	☐
Bed wetting	☐	☐
Prostate trouble	☐	☐

Gastrointestinal

Poor digestion	☐	☐
Indigestion	☐	☐
Excessive hunger	☐	☐
Belching or gas	☐	☐
Nausea / Vomiting	☐	☐
Abdominal pain	☐	☐
Constipation	☐	☐
Diarrhea	☐	☐
Haemorrhoids	☐	☐
Liver concerns	☐	☐
Gall bladder trouble	☐	☐
Bladder concerns	☐	☐
Ulcer	☐	☐
Diabetes	☐	☐

Infections / Illnesses

	current	previous
Herpes	☐	☐
Hepatitis	☐	☐
Plantar warts	☐	☐
TB	☐	☐
HIV / AIDs	☐	☐
Cancer	☐	☐
Allergies	☐	☐

Muscles and Joints

Stiff neck	☐	☐
Backache	☐	☐
Swollen joints	☐	☐
Painful tail bone	☐	☐
Foot trouble L / R	☐	☐
Shoulder pain L / R	☐	☐
Elbow pain L / R	☐	☐
Wrist pain L / R	☐	☐
Hip pain L / R	☐	☐
Knee pain L / R	☐	☐
Arthritis	☐	☐
Weakness / loss strength	☐	☐

Women's Health

Painful menstruation	☐	☐
Excessive flow	☐	☐
Irregular cycle	☐	☐
Hot flushes	☐	☐
Cramps or backache	☐	☐
Vaginal discharge	☐	☐
Swollen breasts	☐	☐
Lumps in the breast	☐	☐

Are you pregnant? Yes ☐ No ☐

On birth control? Yes ☐ No ☐

# of pregnancies _____

# of children _____

Do you smoke? Yes ☐ No ☐

Do you consume alcohol or recreational drugs? If so, please list _____

Are you on any medications / supplements? If so, please list _____

Have you ever had any accidents / fractures / falls / injuries / hospitalizations / surgeries? Yes ☐ No ☐