Kristin Wootton
Naturopathic Doctor
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Balance Integrative Health
1960 Appleby Line, Suite 25
Burlington, ON
L7L 0B7

ADULT INTAKE FORM

Please complete as thoroughly as possible and bring to your first appointment. Please remember to bring any lab work, medications or supplements with you.
All information provided is confidential and will be kept in this office. Information contained in this form will not be released to any person unless authorized by you.

PATIENT CONTACT INFORMATION

Name: _____ **Date (M/D/Y):** _____
Date of Birth (M/D/Y): _____ **Sex (please circle): M F Other:** _____
Address: _____ **Apt/Suite #:** _____
City: _____ **Province:** _____ **Postal Code:** _____
Email Address: _____
Phone: Primary: (____)_____ **Secondary: (____)**_____
May we leave messages (please circle)? Y/N Occupation: _____

EMERGENCY CONTACT INFORMATION

Name: _____ **Relationship:** _____
Contact Information: _____

HEALTH CARE PROVIDERS

Name: _____
Specialty: _____
Phone: (____)_____
Reason for seeing them: _____
_____

Name: _____
Specialty: _____
Phone: (____)_____
Reason for seeing them: _____
_____

Other: _____

How did you hear about the clinic (circle):
Patient referral Website Social Media Information Session Other: _____

Have you consulted a naturopathic doctor, nutritionist, homeopath or other natural health provider before (please circle)? Yes/No
If yes, please state the reason and experience: _____

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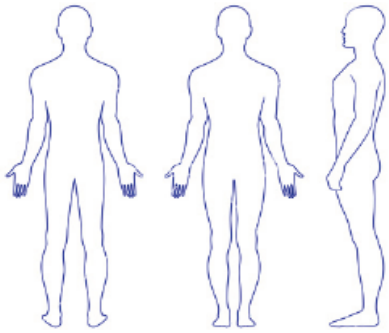
HEALTH GOALS

What are your health goals, in order of importance?

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____

If female, are you currently pregnant? Yes/No

Please indicate areas of distress or pain (circle on diagram below):



MEDICAL HISTORY

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

Please indicate any current or past medical conditions, illnesses, injuries, hospitalizations, etc along with the approximate dates:

1) _____ year _____
2) _____ year _____
3) _____ year _____
4) _____ year _____

Other: _____
_____
_____
_____
_____

Allergies (including drugs, foods and environmental/chemical):
_____

Date of last Physical Exam: _____ **Date of last Blood test?** _____

Immunization History : Any reactions to vaccinations? _____

MEDICATIONS

Please list all current medications/natural health products (including prescriptions, over the counter products, supplements, vitamins, etc) and the conditions it treats

1) _____
2) _____
3) _____
4) _____

Do you frequently use any of the following (circle)?
Aspirin/Tylenol/Advil/other pain relievers
Tobacco
Alcohol
Caffeine
Recreational Drugs

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FAMILY HISTORY

Please circle any health conditions that apply to any family member (sibling, parent, grandparent):

Condition	Family Member	Condition	Family Member
Alcoholism		Diabetes	
Heart Disease/Stroke		Kidney Disease	
Arthritis		Thyroid Concerns	
Asthma		Osteoporosis	
Cancer		Mental health concerns	
Cataracts		Multiple Sclerosis	
Celiac disease		Colitis/Crohns	
Epilepsy		Eczema/Psoriasis	
Depression/Anxiety		Other: _____	

LIFESTYLE

Diet:
Do you have any food intolerances or dietary restrictions?
_____

Exercise:
Do you engage in regular physical activity (please circle)? Yes/No
What activities do you enjoy (how much and how often)? _____
_____

Hobbies: _____

Environment:
Are you exposed to significant tobacco smoke, animals, solvents, heavy metals, pesticides/herbicides or other toxins at home, school, etc (please circle): Yes/No

Are you sensitive to perfumes or other vapors from carpets, paints, etc (please circle): Yes/No

Emotional Health: What is your current level of stress: please rate from 1-10 (10 = highest): _____

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