Benna Lun BSc(Hons) ND
Naturopathic Doctor

Adult (Age 16+) Intake Form

Today's Date: _____

PATIENT INFORMATION (Please print in block letters)

Full Legal Name: _____ _____ _____
First name Middle name Last name

By what name do you prefer to be called? _____

Date of Birth (MM/DD/YYYY): _____ Current Age: _____ Sex: _____

Address: _____ _____
Street address Apartment #

_____ _____ _____
City Postal code Province

Please provide your contact information below and indicate whether or not we may leave messages relating to your appointments:

		Message?			Message?
(H) Phone			(C) Phone		
(W) Phone			E-mail		

EMERGENCY CONTACT INFORMATION

Name: _____ Relationship: _____

Phone numbers: H: ( ) _____ OTHER: ( ) _____

HOW DID YOU HEAR ABOUT DR. LUN?

- ☐ Website
- ☐ Passing by clinic
- ☐ Pamphlet/Flyer
- ☐ Clinic patient
- ☐ Referred by another patient
- ☐ Referred by staff member
- ☐ Referred by health care provider: _____
- ☐ Other (please specify: _____

HEALTH CARE PROVIDERS

Do you have regular screening tests run (e.g. annual physical, blood/urine tests)? (Please circle) Yes No

Please list the health care providers from whom you currently receive treatment (complete as best you can):

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

_____ _____

Phone: ( )_____ Phone: ( )_____

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Health care providers (continued)

Name: _____ Name: _____

Type of care: _____ Type of care: _____

Address: _____ Address: _____

_____ _____

_____ _____

Phone: ( )_____ Phone: ( )_____

CHIEF CONCERNS

Please list the top health care concerns for which you are seeking treatment in order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

MEDICAL HISTORY

How is your general state of health? (Please circle) Excellent Good Average Fair Poor

Please list any past health concerns, including major illnesses, hospitalizations, surgeries, etc., with approximate dates:

1. _____

2. _____

3. _____

4. _____

5. _____

Do you have any allergies (medication, seasonal, environmental, etc.)?
(Please circle) Yes No

If yes, please describe: _____

_____

If you are female, are you currently pregnant or are hoping to become pregnant in the near future?
(Please circle) Yes No

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Please complete the following table regarding medications and supplements:

CURRENT medications			
Drug name	Date started	Dose	What is this drug being taken for?
PAST medications			
Drug name	Date ended	Dose	What was this drug being taken for?
CURRENT supplements (including vitamins, minerals, herbs, homeopathics, etc.)			
Supplement name	Date started	Dose	What is this supplement being taken for?

Do you regularly use any over-the-counter (non-prescription) medications? Please list:

_____

_____

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Please complete the following table:

	Amount per day/week/month
Caffeine (coffee, chocolate, tea, etc.)	
Tobacco (cigarettes, chewing tobacco, etc.)	
Alcohol (beer, wine, liquor, etc.)	
Recreational drugs (marijuana, cocaine, heroin, etc.)	

IMMUNIZATION HISTORY

Is there anything remarkable about your immunization history? Please describe: _____

_____

Have you ever experienced a negative reaction from an immunization, including the "flu" shot? Please describe:

_____

_____

DIET

What do you eat on a typical day? Please indicate examples and quantities.

Breakfast: _____

_____

Lunch: _____

_____

Supper: _____

_____

Snacks: _____

Beverages: _____

How are your meals usually prepared (Please circle)? At home Purchased Both

Do you have any food allergies, sensitivities, or intolerances (that you know of)? (Please circle) Yes No

Please describe: _____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)? (Please circle) Yes No

Please describe: _____

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FAMILY MEDICAL HISTORY

Please indicate any health conditions occurring in your family. Include parents, siblings, children, grandparents, aunts, and uncles.

Health condition	Family member(s)
Heart disease (heart attack, stroke, etc.)	
High blood pressure	
Diabetes	
Asthma	
Eczema or other skin condition	
Thyroid disease (Hypo or Hyper?)	
Arthritis/Rheumatism/other muscle or joint condition	
Cancer (Please indicate type)	
Mental illness (e.g. depression, anxiety, schizophrenia, etc)	
Environmental/seasonal allergies	
Other (please describe):	

☐ I don't know my family medical history

LIFESTYLE

What is your current occupation? _____

Past occupation(s) that relate to your case? _____

What are your hobbies?_____

_____

_____

Please describe types and amounts of physical activity/exercise: _____

_____

_____

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Are you exposed to significant amounts of smoke (including tobacco smoke) or other forms of pollution through work, hobbies, home environment, etc.? (Please circle) Yes No

Please describe: _____

_____

Are you frequently exposed to animals (including pets)? (Please circle) Yes No

Please describe: _____

_____

HOME: How would you describe the emotional environment in your home? _____

_____

_____

_____

STRESS: How stressful is your work and other aspects of your life? _____

_____

_____

_____

How well do you feel you handle stress? _____

_____

_____

_____

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

_____

_____

_____

Thank you for taking the time to complete this form

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