Naturopathic Intake for Gudrun M. Welder, ND

Todays date:

First Name: **Last Name:**

Birthday (DD/MM/YY): **Age:**

Home Address:

City: **Postal Code:**

Home Phone: **Other phone:**

Email:

Height and Weight:

Name of Current General Practitioner (MD):

Reason for last visit:

Date of Last visit to GP: (DD/MM/YY)

Are you seeing a Medical Specialist? **If yes, Name of Specialist:**

Reason for seeking a medical specialist:

Emergency Contact Name: **Number:**

Relation to You:

Main health challenge:

_____

_____

_____

Other challenges_____

_____

_____

Have you had previous care from a □ Naturopath □ Chiropractor □Massage Therapist □Other?

If yes, name of practitioner:

Date of visit if in the past two years:

Have you had any recent X-rays, CT Scans or MRI's? If yes, when (DD/MM/YY):

Please list any hospitalizations, surgeries or major accidents (including MVA's you've had and the date)

_____

_____

_____

Please list any Medications or Supplements you are taking and state reasons for taking it.

_____

_____

_____

Overall stress level: □None □Low □Medium □High

Please say a little about your stress:

_____

_____

How often do you exercise? **Type of exercise?**

Do you currently smoke? □yes □no how many per day? How long have you smoked?

For Women

Are you pregnant? Do you have children? If yes, how many?

Menstrual Cycle: □regular □irregular □cramps □painful cycle □other _____

Date of your last breast exam (DD/MM/YY): Date of last Pap (DD/MM/YY):

Change in libido?

For Men

Difficulty Urinating? Frequent urination at night?

Change in sexual Function? □yes □no Change in libido?

Any other concerns?

Health History

Did you receive general childhood vaccinations?

Allergies: Please list all allergies or hypersensitivities in the following categories

Medications: _____

Foods: _____

Environmental/Chemical _____

Review of Systems (please circle)

General

Insomnia Fatigue Weight Loss Weight Gain

Head

Headache Dizziness Head Trauma Fainting Black out

Eyes

Itching/Redness Change in Vision Cataracts Light Sensitivity Glaucoma

Ears

Infections Ringing/Tinnitus Impaired Hearing Earache Drainage

Mouth

Bleeding Gums Cold sores Jaw/TMJ Problems Canker Sores

Throat

Sore throat Hoarseness Swollen Glands Goiter Swallowing Problems

Nose

Hay fever Loss of smell Nosebleeds Sinus problems Snoring

Lungs

Difficulty breathing Shortness of Breathing Persistent cough Coughing phlegm

Coughing Blood Asthma Pneumonia Emphysema Bronchitis Infections

Vascular

Chest/Heart Pain Heart Palpitations Heart Disease Ankle Swelling Cold feet/hands

Toe Nail Fungus Leg Cramps Calf Pain Varicose Veins Low Blood Pressure

High Blood Pressure Leg or foot sores that don't heal

Gastro-Intestinal

Bloating/Gas Heartburn Ulcers Liver disease Gall bladder disease

Vomiting/nausea Abdominal Pain Diarrhea Constipation

Blood in Stool Haemorrhoids Hernias Enlarged Abdomen/Belly

Urinary

Difficulty urinating Pain urinating Blood in Urine Incontinence

Urinary Urgency Frequent Urination Frequent Infections Kidney Stones

Neurological

Seizures/epilepsy Strokes Tingling Sensation Numbness Muscle Weakness
Difficulty Walking Poor Coordination Paralysis Speech Problems Loss of Memory

Muscle & Bone

Joint pain Swollen joints Stiffness Muscle ache Foot trouble Arthritis Bone Pain
Fractures Dislocation

Skin

Rash itching Hives Dry Acne Psoriasis Eczema Other

Endocrine

Diabetes Hypoglycaemia Hormone Therapy Thyroid Problems Excessive thirst

Heat/Cold Intolerance Excessive hunger Excessive sweating Night Sweats

Emotional

Depression Mood swings Anxiety/nervousness Tension Phobias

Alcohol/drug abuse Addiction

Conditions

AIDS/HIV Eating disorders Heart condition Rheumatic arthritis

Rheumatic fever Alcoholism Cancer/tumour Polio Parkinson's

Multiple sclerosis Gout Anemia Osteoporosis Osteoarthritis

High Cholesterol Fibromyalgia Chronic fatigue Hepatitis Migraines

Family History

Arthritis Asthma/allergies Cancer Depression Diabetes Drug/Alcohol abuse

Epilepsy High Blood Pressure High Cholesterol Kidney disease Mental illness

Stroke Other I don't know my family history

Sleep

Do you have trouble falling asleep? Do you have trouble staying asleep?

Do you wake rested in the morning? Time you go to bed? Time you wake up?

Diet

Do you follow any specific regimens or restrictions?

Please describe a typical day's dietary intake (on the next page)

Breakfast

_____

Lunch

Dinner

Snacks

Fluids

_____

Is there anything else that you think I should know?

Are you interested in getting a monthly email newsletter containing articles I have written on health? Yes ___ No___

Patient Consent

Attending N.D. Gudrun M. Welder

Recommended Diagnostic/Therapeutic Procedures:

_____

_____

I, the undersigned, do hereby acknowledge that I have been informed of and understand the recommended diagnostic/therapeutic procedure(s) described above and have discussed to my satisfaction this and any requests for related information with Gudrun .Welder, ND. I further acknowledge and confirm that I have been informed of and understand the procedure(s), with respect to the nature of the procedure, expected benefits, potential risks, side effects and financial cost; the likely consequences of not having the procedure(s), and what alternative course(s) of action are available to me. I understand that I can withdraw my consent at any time. As a result, I do hereby voluntarily provide my informed consent for the recommended procedure(s) specified above.

Patient or Lawful Representative Signature _____

Date Signed _____