Radiant Life
Naturopathic Centre

# Confidential Adult Case History

Please help me to understand your health needs by carefully completing this intake form.

## Patient Information:

**Name:** ______________________ ______________________ **Sex:** _______ **Gender:** ___________

(First) (Last)

**Date of Birth:** ________ ________ _______ **Age:** _____ **Care Card # (PHN):** ______________________

(Month) (Day) (Year)

## Contact Information:

**Phone #:** ______________________________ **May we leave a message at this number? Yes ☐ No ☐**

**Home Address:** __________________________ **City:** ________________ **Province:** ______________

**Postal Code:** _____________ **E-mail:** _________________________ **Relationship Status:** ___________

**Emergency Contact Name:** ___________________ **Phone:** _____________ **Relation:** ____________

**How did you hear about us?** ______________________

## Current Health:

**Do you have any known allergies ? Yes ☐ No ☐ If yes, please list:** ___________________________

**Height:** _________ **Weight:** _______ **lbs. Any recent weight changes?** ___________________________

**Your main health concerns in order of importance:**

**1.** _____________________________________ **4.** ________________________________________

**2.** _____________________________________ **5.** ________________________________________

**What are your expectations for this visit?** ___________________________________________________

**Please list any medications and natural supplements you are currently taking, with dosages:** ___________

_____________________________________________________________________________________

**How often do you consume/partake in the following? (daily, weekly, monthly, yearly, in the past, never)**

**Alcohol?** _________ **Cigarettes?** __________ **Marijuana?** _________ **Recreational drugs?** _________

**Coffee?** __________ **Pop?** _______________ **Sugar?** _____________ **Exercise?** _________________

**What do you do for work?** _________________ **Do you enjoy it?** ___________

**Past Medical History:** Please list all past hospitalizations, surgeries, accidents and major illnesses:

________________ **Year:** ______ ________________ **Year:** ______

________________ **Year:** ______ ________________ **Year:** ______

**Family Medical History:** Has anyone in your immediate family been diagnosed with any of the following?

☐ Autoimmune condition ☐ Diabetes ☐ Heart Disease ☐ Cancer: type(s) ______

☐ Mental illness ☐ Thyroid disease ☐ Other ____________________

**Overview of Body Systems:**

**General**
- ☐ Night sweats
- ☐ Headaches / Migraines
- ☐ Sweat easily
- ☐ Numbness or tingling
- ☐ Lightheadedness
- ☐ Dizziness
- ☐ Fainting

**Eyes**
- ☐ Eye pain
- ☐ Light sensitivity
- ☐ Hearing loss/impairment
- ☐ Visual loss/impairment
- ☐ Blurred vision

**Ears**
- ☐ Ear aches/infections
- ☐ Ringing in ears

**Nose & Sinuses**
- ☐ Loss of smell
- ☐ Nosebleeds
- ☐ Sinus infections
- ☐ Post-nasal drip
- ☐ Chronic congestion

**Mouth**
- ☐ Loss of taste
- ☐ Mercury fillings
- ☐ Root canals
- ☐ Sores on lips or mouth
- ☐ Painful/Bleeding gums
- ☐ Sores on/painful tongue

**Throat**
- ☐ Swollen/enlarged glands
- ☐ Sore throat
- ☐ Hoarseness
- ☐ Difficulty swallowing
- ☐ Thyroid condition

**Respiratory**
- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Coughing blood
- ☐ Pneumonia/bronchitis
- ☐ Asthma
- ☐ Allergies (pollen, pets)

**Blood**
- ☐ Easy bruising
- ☐ Anemia

**Cardiovascular**
- ☐ High/low blood pressure
- ☐ Heart flutters/skips
- ☐ Chest pain
- ☐ Swelling of limbs
- ☐ Murmurs

**Skin, Hair and Nails**
- ☐ Eczema/Psoriasis
- ☐ Rashes/Hives
- ☐ Itching
- ☐ Acne, boils
- ☐ Rosacea
- ☐ Irregular moles
- ☐ Hair loss

**Musculoskeletal**
- ☐ Muscle pain/spasm where? ______
- ☐ Chronic Injury
- ☐ Joint pain
- ☐ Bone pain

**Gastrointestinal**
- ☐ Nausea
- ☐ Low appetite
- ☐ Heartburn/reflux
- ☐ Gas
- ☐ Blood in stool
- ☐ Undigested food in stool
- ☐ Hemorrhoids
- ☐ Bowel movements: how often: ______

**Urinary**
- ☐ Pain on urination
- ☐ Frequent urination
- ☐ Urinary infections
- ☐ Urinary incontinence
- ☐ Decrease in urine flow
- ☐ Kidney stones

**Sexual**
- ☐ Pain during intercourse
- ☐ Sexually transmitted infection
- ☐ Low/high sex drive
- ☐ Birth control use

**Emotional**
- ☐ Depression
- ☐ Irritability/quick temper
- ☐ Anxiety
- ☐ Abuse of any form
- ☐ Disordered eating

**Male**
- ☐ Hernia
- ☐ Testicular pain/mass
- ☐ Difficulty with erections
- ☐ Prostate problems

**Female - Gynecologic**
- ☐ Menopause: Age of last menses: ____
- ☐ # Births ____
- ☐ # Pregnancies ____
- ☐ Date of last PAP _____
- ☐ Recurrent yeast infection
- ☐ Vaginal discharge
- ☐ Excessive/light flow
- ☐ Painful periods/cramps

**Female - Breast**
- ☐ Breast pain / tenderness
- ☐ Breast lumps
- ☐ Nipple discharge
- ☐ Pain during intercourse

**Neurological**
- ☐ Poor memory
- ☐ Difficulty concentrating