DAWDY NATUROPATHIC CLINIC
RESTORE REPLENISH REJUVENATE
www.dawdynaturopathicclinic.com

ADULT INTAKE FORM

Dr. Kimberly Dawdy, B.A. (HONS), N.D.
6899 Sunset Blvd. Ottawa, ON, K4P 1C5
kim@dawdynaturopathicclinic.com
613-574-0069

PLEASE PRINT CLEARLY IN BLUE OR BLACK PEN

Name: _____ Date: _____

Date of birth: _____ Age: ___ (M/D/Y) Sex: M F

Address: _____

_____

_____

Email: _____

Phone number: Home: _____ Work: _____

Mobile: _____

May we leave messages relating to your visits? Y / N If so which number? H / M / W

Emergency contact: Name: _____

Phone number: _____ Relation:_____

How did you hear about the clinic? _____

Other health care providers you are seeing (family doctor, specialist, chiropractor, etc…):

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

_____ _____ _____

( ) _____ ( ) _____ ( ) _____

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What are your main health concerns, in order of importance to you?

1. _____

2. _____

3. _____

4. _____

5. _____

If you are female, are you pregnant? Yes No (circle one)

MEDICAL HISTORY

How would you describe your general state of health? (circle one)

Excellent Good Fair Poor

Please list all major illnesses, injuries and hospitalization with dates:

_____
_____
_____
_____

Do you have any allergies (food, drugs, environmental, etc.)?

_____
_____
_____
_____

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Please list all current medications with dosages (prescription and over-the-counter):

_____
_____
_____
_____

Please list all current supplements and natural health products with product company names (vitamins, herbs, homeopathics):

_____
_____
_____
_____

Please list past prescription medications:

_____
_____
_____
_____

How many times have you been treated with antibiotics: _____

Do you frequently use any of the following? (check all that apply)

- ◯ Pain medication (Tylenol, Aspirin, Advil, etc…)
- ◯ Low dose Aspirin
- ◯ Laxative antacid/heart burn medication
- ◯ Diet pills
- ◯ Birth control (pill / implants / injection)
- ◯ Coffee/tea (if yes, how much per day) _____
- ◯ Alcohol (if yes, how much per week) _____
- ◯ Cigarettes (if yes, how much per day/week) _____
- ◯ Recreational drugs (if yes, which and how much per week) _____

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Please indicate what immunizations you have had:

◯ DPT (diphtheria, pertussis, tetanus)
◯ MMR (measles, mumps, rubella)
◯ Flu shot
◯ Haemophilus influenza B
◯ Shingles
◯ Tetanus booster; when? _____
◯ Polio
◯ Chickenpox
◯ Other:
◯ Hepatitis A
◯ Hepatitis B
◯ Smallpox
◯ HPV

Have you ever experienced an adverse reaction from a drug, vaccine or natural health product? If yes, please describe:

_____
_____
_____
_____

Do you get regular screening tests done by another doctor? (Blood work, Pap test, prostate exam)? Y / N

DIET

Do you have any food allergies or intolerances? If yes, please list:

_____
_____
_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc…)?

_____
_____
_____

Describe a typical day's diet:

Breakfast

_____

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Lunch

_____

Dinner

_____

Snacks

_____

Beverages

_____

Other

_____

FAMILY HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		**Who?**
Allergies:		Kidney disease:	
Asthma:		Depression:	
Heart disease:		Other mental illness:	
High blood pressure:		Alcoholism/Drug abuse:	
Cancer:		Colitis/Crohn's disease	
Diabetes:		Other:	

◯ I don't know my family medical history

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ENVIRONMENT

Occupation:_____

Hobbies: _____

Do you exercise regularly? Y / N What type? How often?

_____

_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?

Please describe:

_____

_____

How would you describe the emotional climate of your home?

_____

_____

_____

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

_____

_____

_____

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

_____

_____

_____

_____