TRENT HILLS
HEALTH CENTRE

Adult Intake Form

Name_____ Date of 1st visit_____

Date of Birth (y/m/d)_____ Age_____

Address_____

City_____ Province_____ Postal Code_____

Phone (home)_____ Work and/or Cell_____

Can messages be left at: Home Y/N Work/Cell: Y/N

Email_____ Employer_____

Occupation_____ Hrs/wk_____

Marital Status_____ Children_____ Ages_____

Emergency Contact
Name_____ Phone_____
Relationship_____ Address_____
_____

How did you hear about the clinic?_____
Have you received Naturopathic care previously?_____

Other Health Care Providers
1._____ ( )_____
2._____ ( )_____
3._____ ( )_____

Current Health Information
Please list any health/problems in order of importance that you have.
1._____
2._____
3._____
4._____

Have you consulted your MD regarding your health concerns listed, what therapies were prescribed, and what was the result?_____

49 Bridge St. E., Campbellford, ON, K0L 1L0
t.705.632.1112 e. info@andreabullnd.ca
www.trenthillshealth.com

Have you ever been to see a: **Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Other**

What was the therapy given and what were the results?_____
_____

Please list all other prescribed medications you are presently taking. Indicate the name of the drug, dosage, frequency and how long you've taken it.

_____
_____
_____
_____

Have you ever had a bad reaction or allergy to any medication?

_____

How many courses of antibiotics have you had in the past 10 years?

_____

PAST MEDICAL HISTORY

Please list the most significant stressful events of your life (include childhood).

1. _____
2. _____
3. _____
4. _____
5. _____

Have you ever been diagnosed with a serious illness? When?

_____
_____

What hospitalizations or surgeries have you had? When did they occur?

_____
_____

Please list any serious accidents or injuries, and when they happened.

_____
_____

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Which of the following pertain to YOU personally? Please indicate now (N) or in the past (P)?

Allergies	N	P	Weight Problems	N	P	Stroke	N	P	Tonsilitus	N	P
Asthma			Gallstones			Cancer			Miscarriage		
Eczema			Gout			Epilepsy			Varicose veins		
Psoriasis			Arthritis			Migraine			Broken bones		
Ear infections			Thyroid			Pneumonia			Numbness/tingling		
Strep throat			Anemia			Pneumonia			Cold hands/feet		
Measles			High bp			Malaria			Warts		
Scarlet fever			Rhuematic fever			Tuberculosis			Mono		
Chicken pox			Fainting			Small Pox			Depression		
Whooping cough			Poor Memory			Polio			Yeast infection		
Mumps			Balance Problems			Digestive Problems			Mental illness		
Hayfever			Speech Problems			Hemorrhoids			Child abuse		
Diphtheria			Ringing in the Ears			Herpes			Physical abuse		
Canker sores			Hepatitis			Rectal bleeding			Sexual abuse		
Sinusitis			Jaundice			Headaches			Emotional abuse		
Acne			Heart disease			Visual problems			Fibroids		
Chronic fatigue			Alcohol abuse			Sexually transmitted disease			Urinary tract infections		

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Family Health History

	Mother	Father	Siblings	Grandparents	Other blood relative
Cancer					
Tuberculosis					
Heart disease/stroke					
arthritis					
Diabetes					
High blood pressure					
Asthma					
Kidney disease					
Depression					
Substance abuse					
Neurological disease					

Is there anything else pertinent to your health that has not been covered?

_____
_____
_____
_____

Thank you for your time.

I look forward to working with you!

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