Jiselle Griffith BSc., N.D.
Naturopathic Doctor
T: 416.928.9369| **E:** jisellegriffithnd@gmail.com
12 Irwin Ave. Toronto, ON

Naturopathic Adult Intake Form

Name: _____
Date of Birth (MM/DD/YY): _____
Gender: _____
Age: _____ Occupation: _____

Address: _____
_____
_____
Email: _____
Phone: H _____
W _____
C _____

Emergency Contact (Name & Phone): _____

Referred by: _____

Other Health Care Providers:
1. _____ Phone: _____
2. _____ Phone: _____
3. _____ Phone: _____

Your reasons for seeing a Naturopath in order of importance to you:
1. **_____**
2. **_____**
3. **_____**

What factors do you think are causing or contributing to your health concerns?

1. **_____**
2. **_____**
3. **_____**

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

Medical History
List all accidents, surgeries & hospitalizations, include reason and date occurred
1. **_____**
2. **_____**
3. **_____**
4. **_____**

Last Physical Exam _____ Last Eye Exam: _____
Last Routine Bloodwork _____ Last Dental Visit: _____

Allergies (foods, medications, environmental):
_____
_____

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Current Prescription Medications:

Medication	Dosage	Reason for taking	Date Started

Current Supplements (vitamins, minerals, homeopathic, herbs):

Supplement	Dosage	Reason for taking	Date Started

LIFESTYLE

Current Physical Activity (Types and How Often?)

1. _____
2. _____
3. _____

Average Daily Diet

Meal	Time of Day	What's Eaten
Breakfast		
Lunch		
Dinner		
Snacks		

Beverages (type & quantity)

1. _____
2. _____

Smoking	**Y**	**N**	**P**	**If yes, amt per day: _____**
Caffeine	**Y**	**N**	**P**	**If yes, cups per day: _____**
Alcohol	**Y**	**N**	**P**	**If yes, drinks per week: _____**
Other drugs	**Y**	**N**	**P**	**If yes, how often: _____**

Sleep
How many hours per night? _____
If you wake frequently, what is the reason? _____

Stressors
Please list any current stressors or stressful events in past year: _____
_____

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Toxin Exposure

Did you grow up near any refinery, a home with leaded paint, or near a polluted area? If so, what sort of pollution were you exposed to?

_____

Have you had any health problems when you put in new carpeting, painted your home, had new cabinets or did other renovations? If so, please give details:

_____

Have you had any jobs where you were exposed to solvents, heavy metals, fumes, or other toxic materials? If so, please give details:

_____

Are you particularly sensitive to perfumes, gasoline or other vapours?

_____

Have you ever used antibiotics? If yes how many times in your life?

_____

FAMILY HISTORY (if known)

Family Member	Health Issues (e.g. cancer, heart disease, stroke, diabetes, arthritis, mental health, substance abuse, etc)	Current Age, or age of death
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Siblings/Other family		

Review of Systems

Regarding the next long section: Please circle (Y) if you have the problem now, (N) if you never had the problem, (P) if you had the problem in the past

SKIN						**HEAD**					
Rash	Y	N	P	Perspiration	Y N P	Headache	Y	N	P	Oily Hair	Y N P
Warts/Moles	Y	N	P	Itchy	Y N P	Migraine	Y	N	P	Dry Hair	Y N P
Hives	Y	N	P	Cancer	Y N P	Dandruff	Y	N	P	Hair Loss	Y N P
Excessive Dry	Y	N	P			Head Injury	Y	N	P		
EYES						**MOUTH/THROAT**					
Watery	Y	N	P	Cataracts	Y N P	Hoarseness	Y	N	P	Sore Throat	Y N P
Blurry Vision	Y	N	P	Itchy	Y N P	Cold Sores	Y	N	P	Gum Disease	Y N P
Glaucoma	Y	N	P	Dryness	Y N P						

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NECK

Stiffness	Y	N	P		
Swollen Glands	Y	N	P		

MUSCULOSKELETAL

Arthritis	Y	N	P	Stiffness	Y N P
Leg Cramps	Y	N	P	Weakness	Y N P

CARDIOVASCULAR

High Blood Pressure	Y	N	P	Low Blood Pressure	Y	N	P
Murmurs	Y	N	P	Chest Pain	Y	N	P
Palpitations	Y	N	P	Arrhythmia	Y	N	P

URINATION

Incontinence	Y	N	P	Kidney Stone	Y N P
Painful	Y	N	P	Urgency	Y N P
Infections	Y	N	P	Blood	Y N P

DIGESTION

Heartburn	Y	N	P	Bloating	Y	N	P
Diarrhea	Y	N	P	Ulcer	Y	N	P
Constipation	Y	N	P	Vomiting	Y	N	P
Hemorrhoids	Y	N	P	Indigestion	Y	N	P

RESPIRATORY

Cough	Y	N	P	Pneumonia	Y N P
Bronchitis	Y	N	P	Wheezing	Y N P
Shortness Of Breath	Y	N	P	Asthma	Y N P

FEMALE REPRODUCTIVE HEALTH

Age Period Began: _____
Date of Last Period: _____
How Many Pregnancies: _____
Miscarriages: _____
Births: _____
Terminations: _____
Date of Last Pap Test: _____

Any abnormal Pap results?	Y	N	P
Sexually- Transmitted Infection	Y	N	P
Low Libido	Y	N	P

MALE REPRODUCTIVE HEALTH

Testicle Pain Or Swelling	Y	N	P	Prostate Dz	Y N P
Low Libido	Y	N	P	Sexually-Transmitted	Y N P
Hernia	Y	N	P	Infection	

MENTAL/EMOTIONAL

Anxiety	Y	N	P
Depression	Y	N	P
Eating Disorder	Y	N	P
Addictive Behaviour	Y	N	P

Other concern:
_____

NERVOUS SYSTEM

Numbness	Y	N	P
Seizures	Y	N	P
Fainting	Y	N	P
Dizziness	Y	N	P
Vertigo	Y	N	P
Tremors	Y	N	P

Present Weight _____ Height _____
Weight One Year Ago _____
Maximum weight & when _____ Minimum Weight & When _____
Ideal Weight _____

N.D. NOTES: