Carla King, BAS, ND
Naturopathic Doctor

Mandzak Chiropractic Health Centre
101 Mary St. West, #101, Whitby, ON

Adult
Patient Intake Form

Last Name	First Name	Middle Name	
Date of Birth M/D/Y	Occupation	Sex	Age

Contact Information

Street Address	Town/City	Province	Postal Code
Home Phone Number	Alternative Phone Number	May we leave messages regarding your appointment? Yes/No	
Email address			

Emergency Contact Information

Name	Relation	Phone Number
Name	Relation	Phone Number

Other Health Care Providers

Name	Specialty/Focus	Contact Info
Name	Specialty/Focus	Contact Info
Name	Specialty/Focus	Contact Info
Date of Last Medical Visit	Date of Last Physical Exam	Date of Last Blood Work
List of Routine Screening Tests Performed by Other Physicians:		

How did you hear about this clinic?		If referred➔ please let us know by whom:
Have you been treated by a Naturopathic Doctor (ND) before?	Name of ND:	Date of Last Visit

Health History

In your opinion what are your most important health concerns?

1. _____

2. _____

3. _____

4. _____

5. _____

6.

Current Height	Current Weight	Past Max Weight	Past Min Weight

Vaccination / Immunization Record: Check all that apply

Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

- ☐ **DPT (Diphtheria, Pertussis, Tetanus)**
- ☐ **MMR (Measles, Mumps, Rubella)**
- ☐ **Hepatitis B**
- ☐ **Polio**
- ☐ **Varivax/Varilrix (Chicken Pox)**
- ☐ **Pneumococcal Conjugate (Meningitis/Pneumonia)**
- ☐ **Meningococcal C Conjugate (Meningitis)**
- ☐ Other: _____
- ☐ Gardasil/Cervarix (HPV Vaccine)
- ☐ Haemophilus Influenza B
- ☐ Hepatitis A
- ☐ BCG (Tuberculosis)
- ☐ Flu Vaccine

Did any of your vaccines cause adverse reactions, if yes: _____

Which of the following childhood illnesses have you had? Check all that apply:

☐ Asthma	☐ Polio	☐ Mumps	☐ Measles
☐ Rheumatic Fever	☐ Scarlet Fever	☐ Roseola	
☐ Rubella (German Measles)	☐ Whopping Cough	☐ Chicken Pox	

List all Diagnosed Medical Conditions:	**Treatments Received:**	**Year of Diagnosis:**

List all Surgeries/Medical Procedures:	**Reason:**	**Date (Year/Month)**

List all Allergies (medications, foods, supplements, environmental, etc.)	**Reaction Type**

List all prescription drugs (oral contraceptive, etc)**, over-the-counter medications** (pain killers, antacid, etc), **herbs and natural supplements** (vitamins, homeopathics, etc) **that you are taking:**

Medication	Dosage	Start Date

Family History

Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information

Father Age: Related Health History:	**Mother** Age: Related Health History:
Grandmother (Paternal) Age: Related Health History:	**Grandmother (Maternal)** Age: Related Health History:
Grandfather (Paternal) Age: Related Health History:	**Grandfather (Maternal)** Age: Related Health History:
Siblings Age M/F Health History 1. 2. 3.	**Children Age M/F Health History** 1. 2. 3.

Dietary & Lifestyle Habits

Exercise	How many times do you exercise per week? 1x 2x 3x 4x 5x 6x 7x For how long? _____(min) What kind of exercise? Strength Building Cardio/Aerobic Flexibility	
Diet	Are you currently dieting? Yes/ No Is it physician prescribed diet? Yes/No Do you have any dietary restrictions? Yes/No Please List:_____ On average how many meals do you eat each day: _____	
Relationships & Sexuality	Are you currently sexually active? Yes/No Describe your sexuality: Heterosexual Homosexual Bisexual Do you experience any pain/discomfort during intercourse? Yes/No	List any contraceptive method(s) used, if any: - - -
Caffeine	#cups consumed per day: Coffee: #_____ Tea: #_____ Cola:#_____	
Tobacco	Do you use tobacco: Yes/No	If YES, how many/day?
	What type(s) of tobacco:	How Many Years?
	Are you exposed to second hand smoke?	
Alcohol	Do you consume alcohol? Yes/No How many drinks per week: _____	What type(s) of alcohol do you consume?
Drugs	Do you **currently use** recreational drugs? Yes/No ➔If YES – which kind(s), and how often: Have you used recreational drugs **in the past**? Yes/No ➔If Yes – which kind(s), and how often:	
Sleep	On average how many hours/night? _____ Do you have trouble falling asleep? Yes/NO	Do you wake up during the night? Yes/No How many times? _____
Energy	On a scale 1(lowest)➔10(highest), rate your energy level:	
Stress	What are sources of stress in your life:	
Toxins	What is your occupation:	Are you exposed to toxins? Please specify
	How is your house heated?	