Sandra Koch B.Sc., ND: Adult Intake

Name: _____ Age: ____ Gender: Male/Female

Date of Birth: (___ / ___ / ___)
D M Y

Address: _____
Street City Postal Code

Home Phone: ( ) _____ Work Phone: ( ) _____

May we leave messages relating to your visit at your: Home: Yes / No Work: Yes / No

Marital Status: S M D W SEP CL Number of Children: _____ Referred by: _____

Occupation: _____ Employer: _____

Person to contact in case of emergency: _____ Relationship: _____

Home Phone: ( ) _____ Work Phone: ( ) _____

Other Health Care Providers:

1. _____	2. _____	3. _____
_____	_____	_____
_____	_____	_____
( ) _____	( ) _____	( ) _____

What are your health concerns, in order of importance to you. In your opinion, what do you believe caused these conditions?

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

How would you describe your general state of health? Excellent Good Fair Poor

What other treatments or regimes are you currently following?
(Please include the approximate date sand results)

_____
_____
_____

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates.

_____
_____

Please circle the following conditions/situations you have experienced: **Page 2**

Abscesses	Depression	Herpes Genitalia	Peritonitis	Sunstroke
Alcoholism	Diabetes	Influenza	Pleurisy	Stroke
Allergies	Emphysema	Kidney Disease	Pneumonia	Syphilis
Amnesia	Epilepsy	Leukemia	Prostatitis	Tonsillitis
Arthritis	Gallstones	Malaria	Rheumatic Fever	Tuberculosis
Assault	Goitre	Measles	Rubella	Typhoid Fever
Asthma	Gonorrhea	Miscarriage	Scarlet Fever	Venereal Warts
Cancer	Gout	Mononucleosis	Sexual Abuse	Warts
Chicken Pox	Hay Fever	Mumps	Sexual Assault	Whooping Cough
Cold Sores	Heart Disease	Parasites	Skin Disease	Worms
	Hepatitis	Pelvic Inflammatory Disease	Strep Throat	Yellow Fever
			Sinusitis	

Are there any conditions/situations which you have never fully recovered from? (slips, falls, etc.)

_____

_____

_____

Do you have any allergies (medicines, environmental, etc.) diagnosed or suspected? _____

_____

_____

Please list all current medications including prescriptions, over-the-counter, vitamins, herbs, homeopathics, etc. _____

_____

_____

Please list all past prescription medications. _____

_____

_____

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (please circle)
Aspirin Laxatives Antacids Diet pills Birth Control Pills/Implants/Injections

Alcohol – how much per day or week _____
Tobacco – form and amount per day _____
Caffeine – form and amount per day _____
Recreational Drugs – what and how often _____

Have you lost any weight lately? How many pounds? _____ Intentionally: Yes / No
Do you exercise regularly? Yes / No Hours per week: ____ Type: _____

*** Women Only:** Age of First Menses: _____ # of pregnancies, miscarriages and/or abortions _____

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

Alcoholism _____	Allergies _____	Arthritis _____
Asthma _____	Cancer _____	Depression _____
Diabetes _____	Drug Abuse _____	Heart Disease _____
High Blood Pressure _____	Kidney Disease _____	Mental Illness _____

Other: _____

Please indicate what immunizations you have had:

__ DPT (diphtheria, pertussis, tetanus)	__ Haemophilus influenza B	__ Hepatitis A
__ Tetanus booster: when? _____	__ "Flu"	__ Hepatitis B
__ MMR (measles, mumps, rubella)	__ Polio	__ Smallpox
		__ Chicken Pox

Other: _____

Please indicate if any caused adverse reactions: _____

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Yes / No

Do you have any food allergies or intolerances diagnosed or suspected? Please list. _____

_____

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

_____

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (quantity) _____

Are you frequently exposed to: tobacco smoke? Yes / No Animals? Yes / No

Toxins or other hazards (work, home, hobbies)? Yes / No

How is your home heated? (Oil, Gas, etc.) _____

How would you describe the emotional climate of your home? _____

_____

_____

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

_____

_____

Is there anything that you feel is important that has no yet been covered? Yes / No

Please feel free to add these to the back of this page.

Intake form can be emailed back to nd_sandra@yahoo.com or faxed to (905) 309-0590

Address: 55 Livingston Ave, Grimsby ON