

Adult Intake - Prenatal

Date: _____

Name: _____ Age: _____ D.O.B.: _____

Address: _____

City: _____ Postal Code: _____

Telephone: (home) _____ (work) _____ (mobile) _____

E-mail: _____

Emergency contact: _____ Relationship: _____

Telephone: (home) _____ (work) _____ (mobile) _____

Are you presently under the care of an obstetrician or midwife?

Name: _____ Telephone: _____

How would you prefer to be addressed at the Clinic? _____

How did you hear about us? _____

May we give you reminder calls? Y N

May we leave you telephone messages? Y N

Would you like to be added to our e-mail list and be informed of free lectures or other events presented by Toronto-Centre Naturopathic Medicine? Y N

Profession: _____ Employed: full-time part-time

Employer: _____

Marital status: single married common law same-sex divorced separated

Number of children: _____

GYNECOLOGIC HEALTH HISTORY

Date of last menstrual period: _____ Are you certain of this date? Y N

Was this last menstrual period "normal"? Y N If "no", explain. _____

OBSTETRIC HEALTH HISTORY

Number of previous pregnancies: _____

Number of live births: _____ Number of miscarriages: _____ Number of abortions: _____

History of c-section: Y N History of breech birth: Y N History of twins: Y N

PREVIOUS BIRTH HISTORY

1. Date: _____ Infant weight: _____ Gender: _____ Length of labour: _____

Complications: _____

Comments about this pregnancy/delivery: _____

2. Date: _____ Infant weight: _____ Gender: _____ Length of labour: _____

Complications: _____

Comments about this pregnancy/delivery: _____

3. Date: _____ Infant weight: _____ Gender: _____ Length of labour: _____

Complications: _____

Comments about this pregnancy/delivery: _____

CURRENT HEALTH HISTORY

Other than pregnancy, do you have other specific health concerns (in order of importance to you)?

1. _____

2. _____

3. _____

4. _____

5. _____

Has anything recently changed or become worse? _____

What effect has this had on your life? _____

Known allergies: _____

MEDICATIONS AND SUPPLEMENTS

Please list all prescription and non-prescription medications, including dosage, efficacy and any adverse reactions.

1. _____

2. _____

3. _____

4. _____

5. _____

Please list all supplements, homeopathic remedies, etc. including dosage, efficacy and adverse reactions.

1. _____
2. _____
3. _____

Previous treatments: (Include treatment, date and efficacy of treatment)

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

Please describe any limitations to care that I should be aware of (e.g., time restraints). _____

CURRENT HEALTH PROFILE

Height: _____ Weight: _____ Max. weight: _____ Date of max. weight: _____

Have you recently gained or lost any weight? If so, how much? _____

Tobacco: Y N Smoked _____ years Pack(s)/day: _____ Date stopped: _____

Alcohol: Y N Type: _____ Serving(s)*/day: _____

Coffee: Y N Cup(s)/day: _____ Soft drinks: Y N Serving(s)**/day: _____

Artificial Sweeteners: Y N Teaspoon(s)/day: _____

Dairy foods: Y N

Organic foods: Y N

Foods avoided: _____

Why? _____

If you have not completed a "Weekly Diet Journal", list your dietary intake over the last 24 hours.

B: _____

L: _____

D: _____

*1 serving of alcohol = 1.5 oz. spirits, 4 oz. wine, 12 oz. beer (i.e., 1 "standard" serving)

**1 serving of soft drink = 12 oz. (i.e., 1 can)

Regular exercise: Y N Type: _____ Duration: _____ Frequency: _____

How much time do you spend outdoors on an average day? _____

On a scale of 1-10 (10 = highest), rate your stress _____ and energy levels _____

How many hours do you sleep nightly? _____

Do you wake feeling rested? Y N sometimes

PAST HEALTH HISTORY

Childhood illnesses:

- chicken pox measles mumps rubella rheumatic fever
- scarlet fever polio tuberculosis whooping cough

Hospitalizations, surgeries, serious injuries: (Include date and reason for hospitalization)

Have you ever used antibiotics? Y N Date/dosage/duration: _____

For what condition? _____

Birth control method used: _____ Dosage/duration: _____

FAMILY HEALTH HISTORY

Please check the appropriate boxes for immediate family (i.e., grandparents, parents, siblings).

- allergies/hay fever eating disorders psychiatric illness
- asthma epilepsy obesity
- arthritis gout stroke
- bleeding problems heart problems substance abuse
- cancer high blood pressure thyroid disease
- diabetes kidney problems tuberculosis

Age and health status of immediate family:

Mother: _____

Father: _____

Maternal grandmother: _____

Maternal grandfather: _____

Paternal grandmother: _____

Paternal grandfather: _____

Sister/brother: _____

Sister/brother: _____

Sister/brother: _____

Sister/brother: _____

Is there anything else I should be aware of? _____

REVIEW OF SYSTEMS

Please circle "Y" if you are presently experiencing a symptom/condition and "P" if you have experienced it in the past.

GENERAL

change in thirst Y P
 change in appetite Y P
 fatigue/weakness Y P
 fever/chills Y P

HAIR/SKIN/NAILS

hair loss Y P
 skin dryness Y P
 itching Y P
 rash/hives Y P
 boils Y P
 moles Y P
 acne Y P
 eczema Y P
 psoriasis Y P
 warts Y P
 nail ridging/spots Y P
 nail clubbing Y P
 Other: _____

HEAD

headaches Y P
 migraines Y P
 dizziness Y P
 injury Y P
 Other: _____

EYES

prescription
 eyewear Y P
 impaired vision Y P
 pain Y P
 itching Y P
 dryness Y P
 tearing Y P
 redness Y P
 discharge Y P
 sensitivity to sunlight Y P
 blind spots Y P
 glaucoma Y P
 cataracts Y P
 Latest eye exam: _____
 Other: _____

EARS

impaired hearing Y P
 ringing Y P
 earache Y P
 itching Y P
 discharge Y P
 excessive wax Y P
 infection Y P
 dizziness Y P
 Other: _____

NOSE/SINUSES

bleeding Y P
 congestion Y P
 hay fever/allergies Y P
 sinus problems Y P
 injury Y P
 Other: _____

MOUTH/THROAT

mouth dryness Y P
 loss of taste Y P
 gum problems Y P
 dental caries Y P
 chancre sores Y P
 thrush Y P
 hoarseness Y P
 frequent sore throat Y P
 Other: _____

NECK

pain/stiffness Y P
 lumps Y P
 swollen glands Y P
 goiter Y P
 Other: _____

RESPIRATORY

cough Y P
 bloody sputum Y P
 wheezing Y P
 difficulty breathing Y P
 pain on breathing Y P
 bronchitis Y P

asthma Y P
 emphysema Y P
 pneumonia Y P
 tuberculosis Y P
 Latest chest x-ray: _____
 Latest TB test: _____
 Other: _____

CARDIOVASCULAR

angina/chest pain Y P
 heart murmur/
 palpitation Y P
 cyanosis Y P
 high blood pressure Y P
 rheumatic fever Y P
 heart disease Y P
 Latest ECG: _____
 Other: _____

PERIPHERAL VASCULAR

cold hands/feet Y P
 pain in fingers Y P
 tissue swelling Y P
 deep leg pain Y P
 varicose veins Y P
 thrombophlebitis Y P
 skin ulcers Y P
 Other: _____

BLOOD/LYMPHATIC

fatigue/weakness Y P
 skin paleness Y P
 easy bleeding/
 bruising Y P
 clotting problems Y P
 blood transfusion Y P
 lymph node
 swelling Y P
 tissue swelling Y P
 anemia Y P
 hemophilia Y P
 Other: _____

GASTROINTESTINAL

difficulty swallowing Y P
 abdominal pain Y P
 indigestion Y P
 bloating Y P
 belching/flatulence Y P
 heartburn Y P
 nausea Y P
 vomiting Y P
 constipation Y P
 diarrhea Y P
 rectal bleeding Y P
 hemorrhoids Y P
 hernia Y P
 ulcer Y P
 undigested food
 in stool Y P
 decreased drug/
 alcohol/caffeine
 tolerance Y P
 fatigue Y P
 loss of appetite Y P
 fever Y P
 joint/muscle pains Y P
 skin yellowing Y P
 blood sugar
 irregularities Y P
 high cholesterol Y P
 difficulty digesting
 fatty foods Y P
 flank pain Y P
 food allergies Y P
 pancreatic disease Y P
 gallbladder disease Y P
 liver disease Y P
 Other: _____

URINARY

frequent urination Y P
 inability to hold
 urine Y P
 dribbling Y P
 pain on urination Y P
 discoloured urine Y P
 tissue swelling Y P
 low back pain Y P
 fatigue Y P
 muscle twitches Y P

UTI Y P
 kidney disease Y P
 Other: _____

FEMALE

vaginal discharge Y P
 vaginal itching Y P
 vaginal lesions Y P
 Age at first menses: _____
 Length of cycle: _____
 irregular cycle Y P
 bleeding between
 menses Y P
 excessive flow Y P
 painful menses Y P
 PMS Y P
 sexually active Y P
 difficulty conceiving Y P
 decreased libido Y P
 STI Y P
 Latest Pap: _____
 Other: _____

BREASTS

tenderness Y P
 lumps Y P
 nipple retraction Y P
 Perform self-
 examinations Y N
 Other: _____

MUSCULOSKELETAL

joint pain/stiffness Y P
 muscle spasm/
 cramps Y P
 muscle weakness Y P
 joint swelling Y P
 joint nodules Y P
 decreased ROM Y P
 back pain Y P
 TMJ "click" Y P
 fractures Y P
 arthritis Y P
 scoliosis Y P
 sciatica Y P
 carpal tunnel
 syndrome Y P
 Other: _____

NEUROLOGICAL

muscle weakness Y P
 fainting Y P
 involuntary
 movements Y P
 convulsions Y P
 paralysis Y P
 numbness/tingling Y P
 vision problems Y P
 speech problems Y P
 confusion Y P
 loss of balance Y P
 loss of memory Y P
 moodiness Y P
 learning difficulties Y P
 stroke Y P
 dementia Y P
 Other: _____

CARBOHYDRATE METABOLISM

excessive sweating Y P
 nervousness Y P
 confusion Y P
 fungal infections Y P
 fatigue Y P
 nausea Y P
 excessive thirst Y P
 excessive urination Y P
 hypoglycemia Y P
 diabetes mellitus Y P
 Other: _____

ADRENAL

lethargy Y P
 skin darkening Y P
 weight loss Y P
 dizziness on
 standing Y P
 acne Y P
 increased body hair Y P
 hair loss Y P
 voice deepening Y P
 high blood pressure Y P
 Addison's disease Y P
 Cushing's disease Y P
 Other: _____

THYROID

lethargy	Y	P
cold intolerance	Y	P
hair dryness	Y	P
muscle stiffness	Y	P
weight gain	Y	P
menstrual problems	Y	P
weight loss	Y	P
heat intolerance	Y	P
insomnia	Y	P
heart murmur/ palpitation	Y	P

weakness	Y	P
goiter	Y	P
hypothyroidism	Y	P
hyperthyroidism	Y	P
Other:_____		

PARATHYROID

joint pain	Y	P
nausea	Y	P
constipation	Y	P
muscle weakness	Y	P
kidney stones	Y	P

osteoporosis	Y	P
Other:_____		

PSYCHOSOCIAL

sleep problems	Y	P
mood swings	Y	P
muscle tension	Y	P
phobias	Y	P
depression	Y	P
anxiety	Y	P
alcohol/drug abuse	Y	P
Other:_____		