Troy Naturopathic

Website: www.troynaturopathic.com
Email: drdimpi@troynaturopathic.com
Phone: (248) 906-8889

ADULT INTAKE FORM

PLEASE COMPLETE THIS FORM AND BRING IT TO YOUR INITIAL APPOINTMENT

First Name: _____ Last Name: _____ Date: ____/____/_____ (MM/DD/YYYY)

Date of Birth: _____/_____/_____ (MM/DD/YYYY) Gender Identification: ☐ Male ☐ Female ☐ Other_____

Address: _____
Street City State Zip Code

Phone: (HOME) (_____) _____ (WORK) (_____) _____ (CELL) (_____) _____

Best Number to leave messages? ☐ Home ☐ Work ☐ Cell

Emergency contact: _____ Phone: (_____) _____ Relationship to Patient: _____

Please list the other healthcare providers / specialists you are seeing:

Name: Type of Practitioner: **GP / Primary Care Physician** Address: Phone: Fax:	Name: Type of Practitioner: Address: Phone: Fax:
Name: Type of Practitioner: Address: Phone: Fax:	Name: Type of Practitioner: Address: Phone: Fax:

Relationship Status: ☐ Single ☐ Married ☐ Partnership ☐ Separated ☐ Divorced ☐ Widow(er)

Spouse/Partner: First Name: _____ Last Name: _____

Child(ren) Name/Age:

Name:	Age	Name	Age
1.		3.	
2.		4.	

Employment Status: ☐ Full Time ☐ Part Time ☐ Retired ☐ Not Employed

Occupation: _____ Employer: _____ Hours per Week: _____

Hobbies/Interest:

_____

Please list, in order of importance, the reason(s) for your visit today

1. _____ 2. _____

3. _____ 4. _____

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What are your current health goals?

1. _____ 2. _____

3. _____ 4. _____

MEDICAL HISTORY:

Please list all of your current and past medications & supplements in the medications / supplements form.

If you are female are you currently pregnant? ☐ YES ☐ NO

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

Condition / Illness / Injury / Hospitalization	Date

Do you have any allergies (medicines, environmental, food etc.)?

Allergy to:	Please describe your reaction

Do you consume alcohol? ☐ YES ☐ NO How many drinks do you consume per day? _____ How many per week? _____

Do you smoke or chew tobacco? ☐ YES ☐ NO How much a day? _____ How much a week? _____

Do you consume caffeine? ☐ Soda/Pop ☐ Coffee ☐ Tea ☐ Other _____ How much a day? _____

Do you do any recreational drugs? ☐ YES ☐ NO If yes, then what? _____ How often? _____

Do you have any of the following dietary restrictions?

☐ Gluten-free ☐ Sugar-free ☐ Soy-free ☐ Vegan ☐ Vegetarian ☐ Other _____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus)	☐ Haemophilus influenza B	☐ Hepatitis A	☐ Polio	☐ MMRV (measles, mumps, rubella, varicella)
☐ Tetanus booster, when? _____	☐ "Flu"	☐ Hepatitis B	☐ Smallpox	

Other immunizations not listed: _____

Please indicate if any caused adverse reactions: _____

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FAMILY HISTORY:

PGF = Paternal Grandfather	☐ Living ☐ Current age? _____	☐ Deceased ☐ At what age? _____
PGM = Paternal Grandmother	☐ Living ☐ Current age? _____	☐ Deceased ☐ At what age? _____
MGM = Maternal Grandmother	☐ Living ☐ Current age? _____	☐ Deceased ☐ At what age? _____
MGF = Maternal Grandfather	☐ Living ☐ Current age? _____	☐ Deceased ☐ At what age? _____
M = Mother	☐ Living ☐ Current age? _____	☐ Deceased ☐ At what age? _____
F = Father	☐ Living ☐ Current age? _____	☐ Deceased ☐ At what age? _____
S = Sister **B** = Brother **MA** = Maternal Aunt **PA** = Paternal Aunt **PU** = Paternal uncle **MU** = Maternal Uncle		

Please indicate if a close relative has/had any of the following: (Use the above abbreviations)

	Indicate which family member(s)		Indicate which family member(s)
Allergies		Diabetes	
Asthma		Depression	
Heart Disease		Alzheimer's	
High Blood Pressure		Drug Abuse/Alcoholism	
Cancer		Kidney Disease	

Do you or a family member have any major medical conditions not covered in the above chart?

_____

ENVIRONMENT:

Do you exercise regularly? ☐ YES ☐ NO

Type of Exercise	Hours / week	Type of Exercise	Hours / week

Are you exposed to significant tobacco smoke? ☐ YES ☐ NO Where? ☐ Work ☐ Home ☐ Other_____

Are you frequently exposed to animals? ☐ YES ☐ NO Where? ☐ Work ☐ Home ☐ Other_____

Are you regularly exposed to toxins or other hazards? ☐ YES ☐ NO Where? ☐ Work ☐ Home ☐ Other_____

Which toxins? _____

Do you experience stress on a regular basis? ☐ YES ☐ NO

Is there anything that you feel is important that has not been covered?

_____

_____

How did you hear about Troy Naturopathic Clinic?

☐ Referral _____ ☐ Google Search ☐ Other_____