Dr. Michelle Mackay Patel, ND
#112 – 11523 100 AVE NW
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NATUROPATHIC ADULT INTAKE

PERSONAL INFORMATION:

First Name(s): _____ Last Name: _____
Date of Birth (mm/dd/yy): ____/____/____ Age: _____
What is your current gender identity?

- ☐ Male
- ☐ Female
- ☐ Transgender Male/Transman/FTM
- ☐ Transgender Female/Transwoman/MTF
- ☐ Genderqueer
- ☐ Additional category, please specify:_____

What sex were you assigned at birth? Male or Female
What pronouns do you prefer?_____

Current Weight: _____ Current Height:_____

Address: _____
City: _____ Province: _____ Postal Code: _____
Phone #: (H): _____ (Cell): _____ (W): _____

Remind me of appointments by phone? (Please circle) YES / NO Email: _____

Emergency contact: _____ Relation: _____ Phone: _____

Current **general practitioner** - MD: _____ Phone: _____ Clinic: _____
List other **health professionals** you are working with and include their area of practice (e.g. Massage)
Practitioner Name: _____ Practitioner Type: _____ Phone: _____
Practitioner Name: _____ Practitioner Type: _____ Phone: _____
Practitioner Name: _____ Practitioner Type: _____ Phone: _____

How did you hear about our clinic? (Please check all that apply)

- ☐ Current patient of Activecare Chiropractic
- ☐ Medical Doctor/Specialist (please provide name): _____
- ☐ Other Health Care Provider (please provide name): _____
- ☐ Activecare Chiropractic Staff
- ☐ Social Media (Facebook, Twitter, etc)
- ☐ Advertising
- ☐ Website (activecarechiro.ca or michellempnd.com)
- ☐ Information Session
- ☐ Other: _____

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HEALTH INFORMATION:

What is your **main health** concern?

Please list **any other** health concerns (physical, emotional or mental) in order of importance:

1.
2.
3.
4.

How do you rate your **overall health**? Poor Fair Average Good Excellent
How do you rate your **overall energy**? Poor Fair Average Good Excellent

MEDICATIONS:

Please list all current medications (prescription and over-the counter):

Medication	Dose/day	How long have you been taking?
1.		
2.		
3.		
4.		
5.		

Please list all vitamins/minerals, herbs or homeopathics:

Supplement and Brand	Dose/day	How long have you been taking?
1.		
2.		
3.		
4.		
5.		

How many courses of antibiotics have you taken in the past 10 years?
Have you had an adverse reaction to a medication? NO/YES If Yes, Please explain:

ALLERGIES:

List all (to medications, pollens, foods, animals etc.):

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CHILDHOOD MEDICAL HISTORY:

Please **CHECK** to indicate if you have had any of the following childhood illnesses

- ☐ Asthma
- ☐ Measles
- ☐ Rheumatic fever
- ☐ Chicken pox
- ☐ Mumps
- ☐ Diptheria
- ☐ Scarlet fever
- ☐ Mono (how long?_____)
- ☐ Tuberculosis
- ☐ Eczema
- ☐ Polio
- ☐ Whooping cough
- ☐ Frequent ear infections/colds
- ☐ Rubella (German measles)
- ☐ Other:_____

IMMUNIZATIONS:

Please **CHECK** to indicate the immunizations you have received

- ☐ DPT
- ☐ Hemophilus influenza B
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ MMR
- ☐ Tetanus
- ☐ Chicken Pox
- ☐ Smallpox
- ☐ Polio
- ☐ Flu shot
- ☐ Other: _____

Any adverse reactions to a vaccination? Briefly describe if applicable

Please list (with approximate dates) any serious illnesses, injuries, surgeries or hospitalizations.

FAMILY HISTORY:

Please indicate whether any of your family members have, or have had, the following:

Condition	Relative	Condition	Relative
Alcoholism		Diabetes	
Allergies		Drug abuse	
Alzheimer's disease		Heart condition	
Arthritis		High blood pressure	
Asthma		Kidney disease	
Cancer (indicate type)		Osteoporosis	
Depression		Stroke	
Other mental illness		Suicide	
Bleeding disorders		Infertility	
Glaucoma		Thyroid Conditions	

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LIFESTYLE FACTORS

Any current **dietary restrictions**? (vegan, vegetarian, etc.) _____

How much **water** do you drink in a day? _____

On average, how many **hours of sleep** do you get each night? _____ Good Quality? Y/N

Do you exercise? Y / N What type(s) of exercise and what frequency? _____

_____

What do you enjoy for **recreation and relaxation**? _____

Do you have a **religious or spiritual practice** you would like us to know about? _____

What is your **occupation**?_____ Do you do **shift work**? Y/N

Do you currently consume any of the following? (Indicate how often, how much and for how long)

- ☐ Alcohol: _____
- ☐ Tobacco: _____
- ☐ Coffee: _____
- ☐ Soft drinks: _____
- ☐ Black tea: _____
- ☐ Marijuana: _____
- ☐ Laxatives: _____
- ☐ Other: _____

Are you frequently exposed to animals? Y / N Type: _____

Exposed to toxins or hazards at home? Y / N List: _____

Exposed to toxins or hazards at work? Y / N List: _____

Relationship status: _____ Number of children and their ages:_____

What is the emotional climate of your home?

_____

_____

Rate your current **stress** level (circle): Low Average High Unbearable

Which factors most contribute to your stress? (circle)

Health Work Money Family Relationship Other: _____

MALE REPRODUCTION

Do you have regular annual health screening tests? (blood work, prostate examination) Y / N

Date of last prostate examination? (month/yr) _____ / _____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception? _____

Any difficulty with urination? Y / N How often do you get up from sleep to urinate at night? _____

Have you had any of the following? (circle)

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Testicular Pain Hernia Sexually Transmitted Infections Discharge Sores

Do you have any sexual problems or concerns? Y / N If yes, please explain: _____

_____

FEMALE REPRODUCTION

Are you currently pregnant? Y / N

Do you get regular PAP smears? Y / N Date of last PAP? (month/year) _____ / _____

Have you ever had an abnormal PAP? Y / N What was the outcome? _____

Age of first period? _____ Is your period regular? Y / N

Length of monthly cycle (days): _____ Average number of days of period or flow (e.g. 3,5,7): _____

Do you have spotting/bleeding between periods? Y / N

Are you menopausal? Y / N If yes, age of last period: _____

Do you experience PMS? Y / N

Relevant **PMS symptoms** (circle):

Bloating Breast Tenderness Irritability Depression
Headaches Mood Swings Food Cravings Other: _____

Are you currently sexually active? Y / N Have you been sexually active in the past? Y / N

Current forms of contraception: _____

Have you ever had a sexually transmitted infection? Y / N

Number of pregnancies: _____ Births: _____ Miscarriages: _____ Abortions: _____

Have you ever had any of the following concerning your **breasts**? (circle)

Pain Lumps Infections Cysts Nipple Discharge

Do you experience vaginal infections? Never Rarely Frequently

Do you experience bladder infections? Never Rarely Frequently

Do you have any sexual problems or concerns? Y / N If yes, please explain: _____

_____

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REVIEW OF SYSTEMS

Please **CHECK** if you are **currently** experiencing any of the following symptoms **OR** write a **"P"** if you experienced it in the past.

GENERAL SYMPTOMS:
- ☐ Headache
- ☐ Head injury
- ☐ Fever
- ☐ Chills
- ☐ Sweats
- ☐ Dizziness
- ☐ Fainting
- ☐ Loss of Sleep
- ☐ Fatigue
- ☐ Nervousness/Anxiety
- ☐ Loss of Weight
- ☐ Numbness/pain (extremeties)
- ☐ Allergies
- ☐ Convulsions
- ☐ Depression

SKIN:
- ☐ Change in mole(s)
- ☐ Hives / allergic reactions
- ☐ Acne / skin eruptions
- ☐ Itching (ears, skin, rectum)
- ☐ Bruising easily
- ☐ Dryness
- ☐ Boils
- ☐ Varicose veins
- ☐ Sensitive skin

KIDNEYS/REPRODUCTIVE:
- ☐ Prostate inflammation
- ☐ Genital lesions
- ☐ Inability to control urine
- ☐ Frequent urination
- ☐ Painful urination
- ☐ Blood in urine
- ☐ Pus in urine
- ☐ Kidney infection
- ☐ Kidney stones
- ☐ Erectile dysfunction
- ☐ Infertility

EARS/EYES/NOSE/THROAT:
- ☐ Dental decay
- ☐ Gum disorder
- ☐ Enlarged thyroid
- ☐ Tonsillitis
- ☐ Sore Throat
- ☐ Hoarseness
- ☐ Enlarged Glands
- ☐ Glaucoma
- ☐ Failing vision
- ☐ Cataracts
- ☐ Eye Pain
- ☐ Ear discharge
- ☐ Deafness
- ☐ Hay Fever
- ☐ Mercury dental fillings
- ☐ Ear ache
- ☐ Nasal Discharge
- ☐ Nose bleeds
- ☐ Nasal obstruction
- ☐ Sinus Infection

MUSCLE & JOINT:
- ☐ Fracture/dislocation
- ☐ Stiff neck
- ☐ Back pain
- ☐ Muscle weakness
- ☐ Swollen joints
- ☐ Painful tailbone
- ☐ Foot problems
- ☐ Pain in shoulders
- ☐ Hernia
- ☐ Spinal curvature
- ☐ Poor posture
- ☐ Arthritis

CARDIOVASCULAR:
- ☐ Low Blood Pressure
- ☐ High Blood Pressure
- ☐ Previous Stroke
- ☐ Hardening Arteries
- ☐ Swelling of Ankles
- ☐ Poor Circulation
- ☐ Paralytic Stroke
- ☐ Irregular Heart Beat
- ☐ Shortness of Breath
- ☐ Chest Pain

GASTROINTESTINAL:
- ☐ Bloating
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Reflux
- ☐ Eating Disorder
- ☐ Belching
- ☐ Gas (flatulence)
- ☐ Nausea
- ☐ Vomiting
- ☐ Vomiting of blood
- ☐ Abdominal Cramps
- ☐ Constipation
- ☐ Diarrhea
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Jaundice
- ☐ Gallbladder issues
- ☐ Irritable Bowel syndrome
- ☐ Crohn's Disease
- ☐ Ulcerative Colitis

RESPIRATORY:
- ☐ Asthma
- ☐ Difficulty breathing
- ☐ Chronic cough
- ☐ Spitting up phlegm
- ☐ Spitting up blood

Thank you for taking the time to fill out this form.

It will help contribute to a treatment protocol that will better your healthcare needs.