Nature's Intentions Naturopathic Clinic
Sushma Shah Hons BSc ND,
1849 Yonge St. Suite 614, Toronto, ON, M4S 1Y2
416 913 4325 (HEAL)
http://www.naturesintentionsnaturopathy.com

Balanced healing for the body, mind and spirit.

PLEASE FILL IN THE REQUIRED INFORMATION IN BLUE / BLACK INK.

We appreciate your taking the time to fill out the intake form accurately. Your cooperation is essential for providing you the highest standard of care. Please note that all the information you provide is confidential.

REGISTRATION INFORMATION

Name: _____
(First) (Middle) (Last)

Today's Date: _____/_____/_____
mm dd yy

Date of Birth: _____/_____/_____ Age: _____ Gender: _____
mm dd yy

Email Address to receive our online newsletter / specials and appointment remainders*
(*only at your request)
_____

Home Address: _____

City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____ Mobile: ( ) _____

May we leave messages on your home phone relating to our visits? Y N

Emergency contact (name): _____ Phone: ( ) _____

How did you find out about our clinic?

- ✔ Referral – Whom may we thank? _____
- ✔ Search Engine (Google, Yahoo, Bing)
- ✔ Newsletter / Magazine / Yellow Pages
- ✔ Billboard
- ✔ Health food store
- ✔ Other _____

Family Physician: _____ Phone: ( ) _____

Other Health Care Providers: _____ Phone:( )_____

CHIEF HEALTH CONCERNS

What are your health concerns? (List in order of importance to you):

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

List any other concerns you may want to discuss:

_____
_____
_____

If you are female, are you currently pregnant? Y N

MEDICAL HISTORY

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

Please indicate if you have had any serious conditions, illnesses, injuries, surgical procedures (including cosmetic procedures) and any hospitalizations along with approximate dates:

_____
_____
_____

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

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathic, etc.):

_____
_____
_____

Please list all past prescription medications:

_____
_____
_____

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How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (Circle)

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol – how much / day or week _____
Caffeine – form and amount / day _____
Recreational drugs – what and how often _____

Please indicate what immunizations have you had (✔):

_____ DPT (diphtheria, pertussis, tetanus) _____ Haemophilus influenza B
_____ Hepatitis A
_____ Tetanus booster _____ "Flu"
_____ Hepatitis B
_____ MMR (measles, mumps, rubella) _____ Polio
_____ Small pox

Did you experience any adverse reactions to past immunizations? _____
_____

Do you get regular screening tests done by another doctor (Pap, blood tests, etc)? Y N

FAMILY HEALTH HISTORY

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

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

❑ I don't know my family medical history

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GENERAL HISTORY

Check the symptoms / conditions which apply to you:

- **Generals**

_____ Noticeable weight loss	_____ Fatigue	_____ Noticeable weight gain
_____ Weakness	_____ Fever	_____ Lowered immunity

- **Skin**

_____ Rashes	_____ Color change	_____ Lumps
_____ Changes in hair / nails	_____ Itching	_____ Dryness
_____ Eczema	_____ Hives	_____ Psoriasis
_____ Boils / Cysts	_____Moles	

- **Head**

_____ Head injuries	_____ Headaches	_____ Migraines
_____ Hair loss	_____ Dandruff	

- **Eyes**

_____ Redness	_____ Pots	_____ Discharge
_____ Specks/Floaters	_____ Excessive tearing	_____ Flashing lights
_____ Double vision	_____ Glaucoma	_____ Blurred vision
_____ Cataracts	_____ Crossed eyes	_____ Blind spots

Do you wear glasses / contacts? _____

Date of last eye exam? _____

- **Ears**

_____ Infection	_____ Ringing in the ears (tinnitus)	_____ Vertigo
_____ Discharge	_____ Earaches	_____ Hearing loss

Do you use hearing aids? _____

Date of last hearing test? _____

- **Nose and Sinuses**

_____ Frequent colds	_____ Hay fever	_____ Nosebleeds
_____ Nasal stuffiness	_____ Discharge	_____ Itching
_____ Loss of smell	_____ Sinus infections	

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- **Mouth and Throat**

_____ Dry mouth	_____ Bleeding gums
_____ Sore tongue	_____ Hoarseness
_____ Spots / sores in mouth	_____ Dental cavities
_____ Heat / cold intolerance	_____ Sore throat
_____ Lumps in neck	_____ Loss of taste
_____ Tonsillitis	_____ Enlarged thyroid
_____ Stiff neck	_____ Cancer

Date of last dental exam? _____

- **Respiratory**

_____ Sputum	_____ Cough
_____ Coughing up blood	_____ Bronchitis
_____ Wheezing	_____ Emphysema
_____ Asthma	_____ Pneumonia
_____ Tuberculosis	_____ Pleurisy
_____ Chest pain	_____ Difficulty breathing

Results of spirometry tests or the lung tests: _____
_____

- **Cardiovascular**

_____ Rapid heart beat	_____ Slow heartbeat
_____ High blood pressure	_____ Heart murmurs
_____ Low blood pressure	_____ Rheumatic fever
_____ Chest pain	_____ Edema / swollen ankles
_____ Palpitations	_____ Difficulty breathing
_____ Blueness of skin (cyanosis)	_____ Cold hands / feet
_____ Thrombophlebitis	_____ Extremity numbness
_____ Deep leg pain	_____ Leg cramps

Results of electrocardiogram or other heart tests:

_____
_____

- **Gastrointestinal**

_____ Trouble swallowing	_____ Hemorrhoids
_____ Heartburn	_____ Constipation
_____ Excessive hunger / thirst	_____ Diarrhea
_____ Poor appetite / thirst	_____ Hypoglycemia
_____ Diabetes	_____ Abdominal pain
_____ Nausea	_____ Food Intolerance / Allergy

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_____ Vomiting
_____ Regurgitation
_____ Jaundice
_____ Hepatitis
_____ Colitis
_____ Hernias
_____ Excessive belching
_____ Passing of gas
_____ Indigestion
_____ Liver or gallbladder problems
_____ Colitis
_____ Excessive bloating

Frequency of bowel movements? _____
Color and size of stools? _____
Change in bowel habits? _____
Any recent bleeding or black tarry stools? _____

- **Genito-Urinary**
  - _____ Dark-colored urine
  - _____ Excessive urination
  - _____ Burning / pain on urination
  - _____ Pus in urine
  - _____ Urgency
  - _____ Dribbling
  - _____ Urinary infections
  - _____ Blood in urine
  - _____ Frequency at night
  - _____ Kidney infection
  - _____ Foul smelling urine
  - _____ Hesitancy
  - _____ Incontinence
  - _____ Kidney stones

- **Musculoskeletal**
  - _____ Muscle or joint pains
  - _____ Arthritis
  - _____ Back pain
  - _____ Broken bones
  - _____ General muscle weakness
  - _____ Stiffness
  - _____ Gout
  - _____ Artificial joints / limbs
  - _____ Muscle spasms / cramps
  - _____ Joint swelling

- **Neurological**
  - _____ Fainting / blackouts
  - _____ Weakness
  - _____ Nervousness
  - _____ Tremors / involuntary motion
  - _____ Tension
  - _____ Depression
  - _____ Difficulties concentrating
  - _____ Convulsions / seizures
  - _____ Loss of balance
  - _____ Paralysis
  - _____ Tingling / pins and needles
  - _____ Speech problems
  - _____ Numbness / loss of sensation
  - _____ Memory changes / loss
  - _____ Irritability
  - _____ Loss of sleep

- **Hematological**
  - _____ Anemia / Thalassemia traits
  - _____ Easy bleeding
  - _____ Any past transfusions
  - _____ Easy bruising

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Any other conditions / symptoms that are not listed above:

_____

_____

DIET

Do you have any food allergies or sensitivities? Please list:

_____

_____

_____

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

_____

_____

Describe a typical day's diet (with quantity)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

LIFESTYLE / ENVIROMENT

Occupation _____

Hobbies _____

Do you exercise regularly? Y N What do you do for exercise, how much and how often?

_____

_____

Are you exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:

_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

_____

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How stressful is your work or other aspects of your life? How do you manage stress?

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

What are your health goals? Please list them in the order of priority?

Thank you for taking time to complete this intake form. We look forward to working with you in your naturopathic care. Please bring this form to your scheduled appointment visit.

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CANDIDA QUESTIONNAIRE

The total score will help you and your physician decide if your health problems are yeast-connected. Scores in women will run higher, as seven items in the questionnaire apply exclusively to women, while only two apply exclusively to men.

** Yeast-connected health problems are almost certainly present in women with scores over 130 and in men with scores over 140.
** Yeast-connected health problems are possibly present in women with scores over 60 and in men with scores over 40.
** With scores of less than 60 in women and 40 in men, yeast is less apt to be the cause of health problems.

SECTION A: HISTORY

For each of your symptoms, circle the number in the point score column. Add total score and record it at the end of this section.

1. Have you taken tetracycline or other antibiotics for acne for 1 month (or longer)?	25
2. Have you at any time in your life taken other broad-spectrum antibiotics for respiratory, urinary, or other infections (for 2 months or longer, or in shorter courses 4 or more times in a 1-year period)?	20
3. Have you taken broad-spectrum antibiotic drug, even one course?	6
4. Have you, at any time in your life, been bothered by persistent prostates, vaginitis, or other problems affecting your reproductive organs?	25
5. Have you been pregnant:	
- 2 or more times	5
- 1 time?	3
6. Have you taken birth control pills:	
- for more than 2 years?	15
- for six months to 2 years?	6
7. Have you taken prednisone or other cortisone-type drugs:	
- for more than 2 weeks?	15
- 4 or 2 weeks or less?	6
8. Does exposure to perfumes, insecticides, fabric shop odors, and other chemical provoke:	
- mild symptoms?	20
- moderate to severe symptoms?	5
9. Are your symptoms worse on damp, rainy, foggy days or in moldy places?	20
10. Have you had athlete's foot, ringworm, other chronic fungal infections of the skin or nails? Have the infections been:	Y/N
- severe to persistent	20
- mild to moderate	10
11. Do you crave sugar?	10
12. Do you crave breads?	10
13. Do you crave alcoholic beverages?	10
14. Does tobacco smoke really bother you?	10

TOTAL SCORE – SECTION A _____

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SECTION B: MAJOR SYMPTOMS

For each of your symptoms, enter the appropriate figure in the point score column:

- if a symptom is occasional or mild	3 points
- if a symptom is frequent and/or moderately severe	6 points
- if a symptom is severe and/or disabling	9 points

Add total score and record it at the end of this section.

Fatigue and lethargy	____
Feeling of being drained	____
Poor memory	____
Feeling unreal	____
Depression	____
Numbness burning or tingling	____
Muscle weakness	____
Muscle weakness or paralysis	____
Pain and/or swelling in joints	____
Abdominal pain	____
Constipation	____
Diarrhoea	____
Bloating	____
Troublesome vaginal discharge	____
Persistent vaginal itching or burning	____
Prostatitis	____
Impotence	____
Loss of sexual drive	____
Endometriosis	____
Cramps and/or other menstrual irregularities	____
Premenstrual tension	____
Spots in front of eyes	____
Erratic vision	____

TOTAL SCORE – SECTION B _____

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SECTION C: OTHER SYMPTOMS

For each of your symptoms, enter the appropriate figure in the point score column:

- if a symptom is occasional or mild	3 points
- if a symptom is frequent and/or moderately severe	6 points
- if a symptom is severe and/or disabling	9 points

Add total score and record it at the end of this section.

Drowsiness	____
Irritability or Jitteriness	____
Un-coordination	____
Inability to concentrate	____
Frequent mood swings	____
Headache	____
Dizziness (loss of balance)	____
Pressure above ears, feeling of head swelling and tingling	____
Itching	____
Other rashes	____
Indigestion	____
Belching and intestinal gas	____
Mucous in stools	____
Hemorrhoids	____
Dry mouth	____
Rash or blisters in mouth	____
Bad breath	____
Joint swelling in mouth	____
Nasal congestion or discharge	____
Postnasal drip	____
Nasal itching	____
Sore mouth	____
Cough	____
Pain or tightness in chest	____
Wheezing or shortness of breath	____
Urgency or urinary frequency	____
Burning on urination	____
Failing vision	____
Burning or tearing of eyes	____
Recurrent ear infections or fluid in ears	____
Ear pain or deafness	____
TOTAL SCORE – SECTION C	____

TOTAL SCORE – SECTION A	____
TOTAL SCORE – SECTION B	____
TOTAL SCORE – SECTION C	____
TOTAL SCORE	____

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DETOXIFICATION QUESTIONNAIRE

No=0 Rare=1 Often=2

1. Do you feel tired, lethargic or sluggish on waking and throughout the day? 0 1 2
2. Do you have difficulty concentrating or have slow or surreal thinking? 0 1 2
3. Do you feel depressed or have mood swings? 0 1 2
4. Do you get more than one or two colds per year? 0 1 2
5. Do you get post-nasal drip, congestion or "stuffed up" in your nose or sinuses on waking or during the day? 0 1 2
6. Do you have bad breath, a coated tongue or a bitter or metallic taste in your mouth? 0 1 2
7. Do you have strong body odor? 0 1 2
8. Do you have strong smelling/ foul urine? 0 1 2
9. Do you have trouble sleeping or feel unrefreshed upon waking? 0 1 2
10. Do you have sore muscles or joints for no apparent reason? 0 1 2
11. Are your nails weak, soft or brittle? 0 1 2
12. Do you have dark circles under your eyes? 0 1 2
13. Do you have digestive disturbances such as bloating, gas or indigestion a couple hours after eating? 0 1 2
14. Do you have less than one bowel movement per day? 0 1 2
15. Do you feel anxious or stressed out? 0 1 2
16. Are you sensitive to odors, foods or chemicals? 0 1 2
17. Do you have allergies to various environmental and household products, dust and molds? 0 1 2

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18. Do you have eczema, dry skin, and acne or skin rashes? 0 1 2

19. Do you gain weight easily? 0 1 2

20. Do you have food cravings – especially carbohydrate rich foods? 0 1 2

21. Do you have pain or discomfort under your right ribcage occasionally or after eating? 0 1 2

22. Does dietary fiber cause constipation? 0 1 2

23. Do you feel like you're not as healthy as other people your age? 0 1 2

TOTAL

1 – 23: YOU MAY BE REQUIRED TO DO A BODY CLEANSE.

23 and more: Time to do a body cleanse or a detoxification diet.

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