ZAWADA HEALTH

Adult Intake Form

Welcome to Zawada Health, where the health of your family is our priority. Offering the services of Naturopathic Doctors, Registered Massage Therapists, an Osteopathic Manual Practitioner and a full product dispensary, we develop customized wellness plans for each member of your family. Using traditional wisdom and modern research, we strive to provide you with safe and effective solutions that fit your lifestyle.

Name: _____
(Last) *(First)* *(Preferred name)*

Height: _____ *Weight:* _____ *Max Weight:* _____ *When?:* _____

Please list your chief health concerns in order of importance:

1. _____
2. _____
3. _____

Please list all medications (prescription, over-the-counter) and natural products (vitamins, herbs, oils) currently taking – including the daily dose/quantity and reason for taking the product

Have you ever used any of the following?

- ☐ Antibiotics for more than 2 weeks
- ☐ Cortisone or other steroids
- ☐ Chemotherapy/radiation
- ☐ Antacids
- ☐ Antihistamines
- ☐ Pain relievers (aspirin, ibuprofen)
- ☐ Drugs for arthritis (Vioxx, Celebrex)
- ☐ Hormone therapy (including fertility treatments)
- ☐ Thyroid medication
- ☐ Stimulants
- ☐ Blood thinners
- ☐ Anti-depressants
- ☐ Laxatives or stool softeners
- ☐ Diuretics
- ☐ Flu vaccination
- ☐ Vaccination for foreign travel
- ☐ Anesthesia
- ☐ Sleeping pills or sedatives
- ☐ Epidural
- ☐ Recreational drugs

Have you ever experienced adverse effects or allergic reactions to any of the above? ☐ Yes ☐ No

If so, please specify. _____

Please list any allergies or sensitivities (food/environmental, medications) you currently have or have had previously

Please list all hospitalizations, surgeries and/or major injuries you have experienced, including the year, outcome and any complications.

Please check off any condition(s) you currently or have previously experienced.

- ☐ Acne
- ☐ Anemia
- ☐ Angina/heart attack
- ☐ Appendicitis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bleeding disorder
- ☐ Cancer
- ☐ Cervical dysplasia
- ☐ Chicken pox
- ☐ Chronic bronchitis
- ☐ Crohn's
- ☐ Diabetes
- ☐ Ectopic pregnancy
- ☐ Eczema
- ☐ Emphysema
- ☐ Endometriosis
- ☐ Enlarged prostate
- ☐ Epilepsy
- ☐ Gallstones
- ☐ Glaucoma
- ☐ Gonorrhea
- ☐ Gout
- ☐ Head injury
- ☐ Headaches/migraines
- ☐ Heart disease
- ☐ Hemorrhoids
- ☐ Hepatitis
- ☐ High blood pressure
- ☐ High cholesterol
- ☐ HIV
- ☐ Hives disease
- ☐ HPV
- ☐ Kidney disease
- ☐ Kidney stones
- ☐ Lupus
- ☐ Measles
- ☐ Memory loss
- ☐ Meningitis
- ☐ Mental illness
- ☐ Miscarriage
- ☐ Mononucleosis
- ☐ Multiple sclerosis
- ☐ Nasal polyps
- ☐ Nerve damage
- ☐ Osteoporosis
- ☐ Parasites
- ☐ Pelvic inflammatory disease
- ☐ Pleurisy
- ☐ Pneumonia
- ☐ Polycystic ovaries
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Sickle cell anemia
- ☐ Sexual transmitted diseases
- ☐ Strep throat
- ☐ Stroke
- ☐ Syphilis
- ☐ Thalassemia
- ☐ Tuberculosis
- ☐ Ulcerative Colitis
- ☐ Varicose veins
- ☐ Whooping cough

REVIEW OF SYSTEMS

Please check off any condition(s) you currently or have previously experienced:

Endocrine

- ☐ 20 lbs change in weight
- ☐ Generally feel hot
- ☐ Generally feel cold
- ☐ Sluggish after coffee
- ☐ Poor concentration
- ☐ Hypoglycemia (low blood sugar)
- ☐ Sluggish after eating
- ☐ Mental dullness

Have you recently lost or gained weight? ☐ Yes ☐ No *How much?* _____

Rate your stress level (1=relaxed, 10=stressed) 1 2 3 4 5 6 7 8 9 10

Rate your energy level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

How many hours of sleep do you get a night? _____

Do you sleep soundly or is your sleep disrupted? _____

Do you wake feeling rested? _____

Immune

- ☐ Chronic infections
- ☐ Frequent antibiotics
- ☐ Cold sores
- ☐ Swollen glands or lymph nodes
- ☐ Slow wound healing
- ☐ Frequent sore throats
- ☐ Poor childhood immune health

Neurologic/Musculoskeletal

- ☐ Paralysis
- ☐ Numbness
- ☐ Joint pain
- ☐ Loss of balance
- ☐ Muscle cramps or spasms
- ☐ Muscle weakness
- ☐ Tingling
- ☐ Loss of memory
- ☐ Vertigo or dizziness

Skin, Hair and Nails

- ☐ Rashes
- ☐ Lumps or abscesses
- ☐ Excessive perspiration
- ☐ Dry skin
- ☐ Warts
- ☐ Itching
- ☐ Change in colour
- ☐ Strong body odor
- ☐ Hair loss
- ☐ Change in size, shape or colour of a mole or freckle
- ☐ Night sweats
- ☐ Brittle nails

How many times have you had a sunburn? _____

Head, Ears, Eyes, Nose, Throat

- ☐ Headaches
- ☐ Migraines
- ☐ Ringing in ears
- ☐ Earaches
- ☐ Impaired hearing
- ☐ Itchy ear canal
- ☐ Cataracts
- ☐ Colour blindness
- ☐ Visual disturbances
- ☐ Poor night vision
- ☐ Far-sighted
- ☐ Near-sighted
- ☐ Dry eyes
- ☐ Nose bleeds
- ☐ Post nasal drip
- ☐ Runny nose
- ☐ Poor sense of smell
- ☐ Loss of smell
- ☐ Gum problems
- ☐ Hoarseness
- ☐ Jaw pain and clicking
- ☐ Teeth grinding
- ☐ Breathe through your mouth

Respiratory System

- ☐ Chronic cough
- ☐ Shortness of breath lying down
- ☐ Chronic phlegm
- ☐ Pain while breathing
- ☐ Cough up blood
- ☐ Shortness of breath during the day
- ☐ Wheezing
- ☐ Asthma
- ☐ Pneumonia

Cardiovascular System

- ☐ Chest pain
- ☐ Hemorrhoids
- ☐ You feel dizzy when you stand up quickly
- ☐ Fainting
- ☐ Heart palpitations
- ☐ Easy bleeding or bruising
- ☐ Cold hands and feet
- ☐ Heaviness or pain in legs
- ☐ Varicose veins
- ☐ Heart murmurs
- ☐ Socks leave imprints on your ankles

Gastrointestinal System

- ☐ Trouble swallowing
- ☐ Nausea
- ☐ Blood in stools or on tissue
- ☐ Mucous in stools
- ☐ Stool floats in bowl
- ☐ Heartburn
- ☐ Bloating
- ☐ Itching around anus
- ☐ Change in thirst
- ☐ Stomach cramps or pain
- ☐ Gas
- ☐ Constipation
- ☐ Black stools
- ☐ Undigested food in stools
- ☐ Change in appetite
- ☐ Burping
- ☐ Diarrhea or loose stools
- ☐ Hard stool
- ☐ Grey stool

How often do you have a bowel movement? _____

Have you ever travelled to a third-world country? ☐ Yes ☐ No

If so, please specify where and for how long? _____

Have you ever had parasites that you are aware of? _____

Urinary System

- ☐ Pain on urination
- ☐ Frequent bladder infections
- ☐ Strong urine odour
- ☐ Inability to hold urine
- ☐ Kidney infections
- ☐ Increased frequency
- ☐ Wake up to urinate
- ☐ Must strain to urinate

Men's Health (if applicable)

- ☐ Hernia
- ☐ Discharge or sores
- ☐ Testicular mass
- ☐ Sexual difficulties
- ☐ Testicular pain
- ☐ Impotence
- ☐ Low sex drive
- ☐ Prostate condition

Are you sexually active? ☐ Yes ☐ No Date of last prostate exam _____

Women's Health (if applicable)

- ☐ Fibrocystic breasts
- ☐ Puckering of skin around nipple
- ☐ Nipple discharge
- ☐ Breast tenderness
- ☐ Flaky or dry skin on nipple
- ☐ Breast lumps or cysts

Do you perform monthly self-breast examinations? ☐ Yes ☐ No

Date of last clinical breast exam _____

Date of last mammogram _____

Age of first menses _____ Age of last menses (if applicable) _____

Cycle length (in days)? _____ Date of last menstrual period _____

Are you currently pregnant? _____ Number of pregnancies _____

If so, how many months/weeks? _____

Are you trying to conceive? _____

Are you sexually active? _____

What type of birth control do you use (if any?) _____

- ☐ Discharge
- ☐ Itching
- ☐ Abdominal pain mid cycle
- ☐ Vaginal dryness
- ☐ Abnormal pap tests
- ☐ Sexual difficulties
- ☐ Sores, growths or lumps
- ☐ Odour
- ☐ Pain during intercourse
- ☐ Menopausal symptoms
- ☐ Abortions
- ☐ Miscarriages
- ☐ Low sex drive
- ☐ Use tampons

Date of last pap test _____

- ☐ Pain or cramping
- ☐ Clotting
- ☐ Diarrhea
- ☐ Water retention
- ☐ Irregular cycles
- ☐ Missed periods
- ☐ Bloating
- ☐ Breast tenderness
- ☐ Heavy flow
- ☐ Bleeding between periods
- ☐ Cravings
- ☐ Light flow
- ☐ Mood Swings
- ☐ Headaches
- ☐ Low back pain

Mental/Emotional

- ☐ Abuse
- ☐ Anxiety or nervousness
- ☐ Depression
- ☐ Easily angered
- ☐ Indecision
- ☐ Irritability
- ☐ Memory problems
- ☐ Mental illness
- ☐ Mood swings
- ☐ Panic attacks
- ☐ Phobias
- ☐ Prolonged sadness or grief

What are the three major stressors in your life?

1._____

2._____

3._____

Has there been an illness or event in your life that you feel you have never fully recovered from? *If so, please specify.*

_____

_____

Lifestyle

Are you currently or have you ever been a smoker? ☐ Past ☐ Never ☐ Currently

If so, how many packs a day? _____

How long have you smoked or when did you quit? _____

Are you exposed to second hand smoke? ☐ Yes ☐ No

Do you use recreational drugs? i.e. marijuana ☐ Yes ☐ No

If yes, please specify type and frequency of use _____

How much time do you spend outdoors per week? _____

How often do you exercise? _____

What kind of exercise do you do? _____

What do you do to relax? _____

Describe your support network. _____

Describe your living situation. _____

Do you have a spiritual practice? ☐ Yes ☐ No

Toxin Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work or while traveling? ☐ Yes ☐ No

Have you ever experienced health problems after putting down new carpeting, painting renovations or having your lawn sprayed with herbicide? ☐ Yes ☐ No

Are you particularly sensitive to perfume, gasoline or other vapor? ☐ Yes ☐ No

Have you ever lived near a refinery or a polluted area? ☐ Yes ☐ No

Have you ever lived in a home more than 50 years old? ☐ Yes ☐ No

Do you have mercury dental fillings? ☐ Yes ☐ No

Have you had any dental root canal procedures? ☐ Yes ☐ No

Do you have any surgical implants? (cosmetic, medical) ☐ Yes ☐ No

Do you live near power lines? ☐ Yes ☐ No

Diet

How much water do you drink per day? _____

How many times per week do you eat red meat? _____

How many times per week do you eat fish? _____

How often do you eat out/order in? _____

What foods do you crave? _____

Do you eat smoked foods? ☐ Yes ☐ No

Do you have any dietary restrictions? ☐ Yes ☐ No

*If so, please specify (*e.g. vegan, religious, allergies) _____

Family Health History

	Age (or age at death)	Health Concerns
Mother		
Father		
Sisters		
Brothers		
Grandparents		

Is there anything you feel is important to note that has not been covered in this questionnaire?

_____

_____

_____

Thank you for answering all the questions.
Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment.

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.

ZAWADA HEALTH

Contact Information & Consent

Name: _____
(Last) *(First)* *(Preferred name)*

Date of Birth: _____ /_____ /_____ *(mm/dd/yyyy)*

Occupation _____

Full Address:

_____

_____

Postal Code: _____

Telephone: *Home:* _____ *Work/Mobile:* _____

Email (for appointment reminders and follow-up): _____

Emergency Contact: _____ *Relation:* _____

Telephone: _____

How did you hear about Zawada Health?

- □ Search Engine
- □ Zawada Health Website
- □ Yellow Pages
- □ Health Fair
- □ Relative or Friend
- □ Coworker
- □ Medical Doctor
- □ Chiropractor
- □ Health Food Store
- □ Registered Massage Therapist
- □ Other Healthcare Practitioner: _____
- □ Other *(please specify)*: _____

With the ***new email legislation*, we require your approval to send you our monthly newsletter, which includes exciting information, delicious recipes, and more (*only one email per month*).

Signature: _____ Email: _____

ZAWADA HEALTH

Acknowledgement and Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration the physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include dietary modification and nutritional supplementation, lifestyle counseling, botanical medicine, homeopathy, traditional Chinese medicine & acupuncture, hydrotherapy, and physical medicine.

During your initial visits your Naturopathic Doctor will take a thorough case history, perform a basic/complaint-oriented physical examination, and when indicated take urine samples or perform other laboratory testing. Even the gentlest therapies may cause complications in certain physiological conditions. This depends dramatically on the individual and the extent of the illness.

Some therapies must be used with caution in certain conditions or diseases such as diabetes, heart/liver/kidney disease, or in young children, those taking multiple medication or pregnancy/lactation. Therefore, it is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, please advise your Naturopathic doctor immediately.

Health risks associated with Naturopathic Medicine include, but are not limited to:

- Aggravation of pre-existing symptoms during the healing process
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Inconvenience of lifestyle changes

The Naturopathic Doctor may prescribe supplements that can be purchased at the clinic or other local options (i.e. health food stores). Most insurance companies do not cover the supplements that we prescribe and dispense.

Signature: _____ Date: _____

Witness: _____ Date: _____

Print Parent/Guardian's Name: _____

Signature of Parent/Guardian: _____