



Family Health Centre

Chiropractic • Naturopathy • Massage Therapy  
Nutrition • Orthotics • Natural Pharmacy • Acupuncture

Dr. Jesse Pierce, Bsc., ND  
Naturopathic Doctor

**Confidential Patient Intake** please print

Today's Date: \_\_\_\_\_

Name: \_\_\_\_\_ Mr. Mrs. Ms. Miss Age: \_\_\_\_\_ Sex: M F

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Blood Type \_\_\_\_\_ (+ or -)

Address: \_\_\_\_\_  
(Street & Apt.) City Province Postal Code

Home Phone: \_\_\_\_\_ Business Phone: \_\_\_\_\_

Cell Phone: \_\_\_\_\_ E-mail: \_\_\_\_\_

Occupation: \_\_\_\_\_ Hours per week: \_\_\_\_\_ Retired \_\_\_\_\_

Employer: \_\_\_\_\_

Single \_\_\_\_\_ Married \_\_\_\_\_ Partner \_\_\_\_\_ Separated \_\_\_\_\_ Divorced \_\_\_\_\_ Widowed \_\_\_\_\_

Live with: Spouse \_\_\_\_\_ Partner \_\_\_\_\_ Parents \_\_\_\_\_ Children \_\_\_\_\_ Friends \_\_\_\_\_ Alone \_\_\_\_\_

Emergency Contact: \_\_\_\_\_ Phone: \_\_\_\_\_  
(Name and Relationship)

How did you hear about us? \_\_\_\_\_

Are you currently receiving healthcare? If yes, where and from whom? \_\_\_\_\_

**Current Health Concerns**

*State the main reason for your visit today. Describe in detail any specific health condition. Include when it started and where, any associated symptoms, and any treatments used for the condition. Is there anything that makes this problem better or worse?*

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_
5. \_\_\_\_\_

**Allergies**

Are you allergic to medicines, herbs, foods, animals, or any other substance?

Substance	Reaction
_____	_____
_____	_____
_____	_____

**Current Medications** (Prescription and over the counter)

Name of Drug	Reason for Drug	Dose (mg/etc)	For how long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Please check (✓) any of the following that you take:

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Antacids (Rolaids/Tums)            | <input type="checkbox"/> Diet pills               | <input type="checkbox"/> Pain Relievers (Aspirin, Tylenol, Motrin) |
| <input type="checkbox"/> Antihistamines (Claritin/Benadryl) | <input type="checkbox"/> Laxatives                | <input type="checkbox"/> Sleeping Pills                            |
| <input type="checkbox"/> Cortisone (cream or pills)         | <input type="checkbox"/> Oral contraceptives /HRT | <input type="checkbox"/> Thyroid Medication                        |
| <input type="checkbox"/> Cough or cold medication           | <input type="checkbox"/> Flu Vaccinations         |  |

**Vitamins, Minerals and Supplements** – What you are taking and dosages

Name of Supplement	Reason	Dose	For how long

**Family History**

Please indicate if any close relative has had any health condition(s) including the following: bloodpressure, heart attack, stroke, diabetes, skin disorders, depression, asthma, allergies, alcohol/drug abuse, cancer, osteoporosis, mental illness

Relationship	Age	Health Conditions
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sister(s)		
Brother(s)		
Aunt(s)		
Uncle(s)		
Children		

**Past Medical History: Childhood Illnesses** (check (✓) if you had it)

- |                                     |                                    |                                     |                                  |  |
|-------------------------------------|------------------------------------|-------------------------------------|----------------------------------|--|
| Chickenpox <input type="checkbox"/> | Coxsackie <input type="checkbox"/> | Diphtheria <input type="checkbox"/> | Fifth's <input type="checkbox"/> | Tuberculosis <input type="checkbox"/>    |
| German <input type="checkbox"/>     | Mono <input type="checkbox"/>      | Mumps <input type="checkbox"/>      | Polio <input type="checkbox"/>   | Rheumatic Fever <input type="checkbox"/> |
| Rotovirus <input type="checkbox"/>  | Smallpox <input type="checkbox"/>  | Typhoid <input type="checkbox"/>    | Measles <input type="checkbox"/> | Whooping Cough <input type="checkbox"/>  |

**Medical Conditions:** Check ( ) if you have had any of the following:

Indicate if it is a Y (Yes -current) or Past Condition (P)

- |   |  |  |   |
|---|--|--|---|
| Y or P                                      | Y or P                                   | Y or P                                       | Y or P                                    |
| <input type="checkbox"/> Allergies          | <input type="checkbox"/> Diabetes        | <input type="checkbox"/> Hepatitis           | <input type="checkbox"/> Seizures         |
| <input type="checkbox"/> Anemia             | <input type="checkbox"/> Ear Infections  | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Substance Abuse  |
| <input type="checkbox"/> Asthma             | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> HIV/AIDS or ARC     | <input type="checkbox"/> Stroke           |
| <input type="checkbox"/> Autoimmune         | <input type="checkbox"/> Eczema          | <input type="checkbox"/> Hypertension        | <input type="checkbox"/> Syphilis         |
| <input type="checkbox"/> Cancer             | <input type="checkbox"/> Fracture        | <input type="checkbox"/> Irritable Bowel     | <input type="checkbox"/> Tonsillitis      |
| <input type="checkbox"/> Canker Sores       | <input type="checkbox"/> Glaucoma        | <input type="checkbox"/> Joint Problems      | <input type="checkbox"/> Ulcers           |
| <input type="checkbox"/> Chronic Fatigue    | <input type="checkbox"/> Gonorrhea       | <input type="checkbox"/> Lung Disease        | <input type="checkbox"/> Venereal Disease |
| <input type="checkbox"/> Chronic Infections | <input type="checkbox"/> Heart Disease   | <input type="checkbox"/> Mononucleosis       | <input type="checkbox"/> Weight Changes   |
| <input type="checkbox"/> Depression/Anxiety | <input type="checkbox"/> Herpes          | <input type="checkbox"/> Pneumonia           |   |

**Hospitalizations and Surgeries:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_  
\_\_\_\_\_ Year: \_\_\_\_\_

**X-Rays, CAT Scans, or Other Diagnostic Studies:**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Accidents/Injuries (Type, Date and Important Details)**

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

**Vaccine History:** (circle if received)

Hep B   Hib   Pertussis   Tetanus   Polio   MMR   HPV   Flu   Other: \_\_\_\_\_  
Any adverse reactions? \_\_\_\_\_

**Current Medical History:**

The general state of your health is:   Excellent \_\_\_\_\_   Good \_\_\_\_\_   Average \_\_\_\_\_   Fair \_\_\_\_\_   Poor \_\_\_\_\_  
What time of day is your energy best: \_\_\_\_\_ worst: \_\_\_\_\_

List some important events in your life from the most recent to the most distant.

1. \_\_\_\_\_ Date: \_\_\_\_\_  
2. \_\_\_\_\_ Date: \_\_\_\_\_  
3. \_\_\_\_\_ Date: \_\_\_\_\_  
4. \_\_\_\_\_ Date: \_\_\_\_\_  
5. \_\_\_\_\_ Date: \_\_\_\_\_

Which event has affected you the most and why? \_\_\_\_\_  
\_\_\_\_\_

**Numerically rate your stress level with each category** (1 is the least and 10 is the most stress)

Family \_\_\_\_\_   Work \_\_\_\_\_   Love Relationship \_\_\_\_\_   Other Relationships \_\_\_\_\_  
Personal Growth \_\_\_\_\_   Spiritual Growth \_\_\_\_\_   Physical Growth \_\_\_\_\_   Mental Health \_\_\_\_\_  
School \_\_\_\_\_   Other? \_\_\_\_\_ please list: \_\_\_\_\_

**Typical Food Intake:**

Breakfast: \_\_\_\_\_  
\_\_\_\_\_

Lunch: \_\_\_\_\_  
\_\_\_\_\_

Dinner: \_\_\_\_\_  
\_\_\_\_\_

Snacks: \_\_\_\_\_

Beverages: \_\_\_\_\_

How much water per day?: \_\_\_\_\_

Do you follow any dietary modifications? \_\_\_\_\_

Do you have any food craving? \_\_\_\_\_ if yes, please list: \_\_\_\_\_

**Regular Exercise:**

Type	Time per Session	Frequency (times per week)	Practiced How Long
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

**Bowel Movement Habits:** Please Check (✓)

Frequency: How often: Every day \_\_\_\_\_ Every other \_\_\_\_\_ Every week \_\_\_\_\_ Other? \_\_\_\_\_  
 Color: Dark \_\_\_\_\_ Brown \_\_\_\_\_ Green \_\_\_\_\_ Yellow \_\_\_\_\_ White \_\_\_\_\_ Gray \_\_\_\_\_  
 Consistency: Soft \_\_\_\_\_ Hard \_\_\_\_\_ Watery \_\_\_\_\_  
 Mucus \_\_\_\_\_ or Blood \_\_\_\_\_ If Blood is present: Bright \_\_\_\_\_ Dark \_\_\_\_\_

**Urine Habits:** Please Check (✓)

Frequency: How often per 24 hour period: \_\_\_\_\_  
 Color: Dark \_\_\_\_\_ Light Yellow \_\_\_\_\_ Colorless \_\_\_\_\_  
 Character: Cloudy \_\_\_\_\_ Clear \_\_\_\_\_ Concentrated \_\_\_\_\_ Dilute \_\_\_\_\_ Any Odor \_\_\_\_\_  
 Any, Sediment \_\_\_\_\_ Blood \_\_\_\_\_ Bright \_\_\_\_\_ Dark \_\_\_\_\_  
 Any, Pain \_\_\_\_\_ Incontinence \_\_\_\_\_ Difficulty with Stream \_\_\_\_\_

**Social History & Habits:** (Y= Yes & N= No).

Main interests and hobbies? \_\_\_\_\_

Average # of hours you sleep per night? _____	Enjoy your work? _____	Y N
Sleep well? _____ Y N	Take vacations? _____	Y N
Awaken rested? _____ Y N	Spend time outside? _____	Y N
Have a supportive relationship? _____ Y N	Watch television? _____	Y N
Have a history of abuse? _____ Y N	→How many hours? _____	
Any major traumas? _____ Y N	Do you drink coffee? _____	Y N
Use recreational drugs? _____ Y N	Do you eat three meals a day? _____	Y N
Been treated for drug dependence? _____ Y N	Do you eat out often? _____	Y N
Drink alcoholic beverages? _____ Y N	Do you go on diets often? _____	Y N
Treated for alcoholism? _____ Y N	Do you drink black or green tea? _____	Y N
Do you use tobacco? _____ Y N	→How many years? _____	
→ packs per day? _____	Do you drink cola or other sodas? _____	Y N
Smoked previously? _____ Y N	→How many years? _____	
→ How many years? _____		

1. Have you ever felt you should cut down on your drinking or drug use? Yes \_\_\_\_\_ No \_\_\_\_\_
2. Have people criticized or complained about your drinking or drug use? Yes \_\_\_\_\_ No \_\_\_\_\_
3. Have you ever felt bad or guilty about your drinking or drug use? Yes \_\_\_\_\_ No \_\_\_\_\_
4. Have you ever had a drink or drug in the morning, an eye opener, to steady your nerves or to get rid of a hangover? Yes \_\_\_\_\_ No \_\_\_\_\_
5. Do you use any drugs other than those prescribed by a physician? Yes \_\_\_\_\_ No \_\_\_\_\_
7. Has your drinking/drug use caused family, job, or legal problems? Yes \_\_\_\_\_ No \_\_\_\_\_

Name of husband/ wife/ partner: \_\_\_\_\_  
 Occupation: \_\_\_\_\_  
 Other members of the household (names and ages): \_\_\_\_\_

Sexually active with: Men \_\_\_\_\_ Women \_\_\_\_\_ Both \_\_\_\_\_  
 Are you sexually active now? Yes \_\_\_\_\_ No \_\_\_\_\_ If No, when were you last sexually active? \_\_\_\_\_  
 How long with current partner? \_\_\_\_\_ Monogamous \_\_\_\_\_ Non Monogamous \_\_\_\_\_  
 Do you practice safe sex? Yes \_\_\_\_\_ No \_\_\_\_\_  
 Do you have any pets? Yes \_\_\_\_\_ No \_\_\_\_\_ Please list: \_\_\_\_\_

**GENERAL HISTORY:**

(For the following list of symptoms: Circle Y for currently experiencing and P for those you've had in the past)

<b>SKIN:</b>		<b>NOSE &amp; SINUSES:</b>		<b>GASTROINTESTINAL:</b>		<b>MALE:</b>	
Rashes	Y P	Frequent colds	Y P	Trouble swallowing	Y P	Hernia	Y P
Eczema	Y P	Nasal stuffiness	Y P	Nausea	Y P	Enlarged prostate	Y P
Psoriasis	Y P	Loss of smell	Y P	Vomiting	Y P	Prostatitis/infection	Y P
Vitilego	Y P	Nose bleeds	Y P	Heartburn	Y P	Discharge	Y P
Dryness	Y P	Nasal Polyps	Y P	Indigestion	Y P	Low libido	Y P
Hives	Y P	Sinus Infections	Y P	Bloating	Y P	Erectile dysfunction	Y P
Boils	Y P	Chronic runny nose	Y P	Abdominal pain	Y P	Last prostate exam: _____	
Acne	Y P	Other: _____		Excessive gas	Y P		
Warts	Y P			Ulcer	Y P	<b>HAEMATOLOGICAL</b>	
<b>HEAD/NECK:</b>		<b>RESPIRATORY:</b>		Hypoglycemia	Y P	Anemia	Y P
Head injury	Y P	Cough	Y P	Diabetes	Y P	Easy bleeding	Y P
Headaches	Y P	Wheezing	Y P	Jaundice/hepatitis	Y P	Easy Bruising	Y P
Migraines	Y P	Coughing blood	Y P	Colitis or Chron's	Y P	Varicose/spider veins	Y P
Vertigo/Dizziness	Y P	Difficulty breathing	Y P	Constipation	Y P	Hep. A, B, or C	Y P
Hair loss	Y P	Shortness of breath	Y P	Blood in stool	Y P	HIV	Y P
Dandruff	Y P	Pain on inhale	Y P	Diarrhea	Y P		
Swollen lymph nodes	Y P	Asthma	Y P	Hemorrhoids	Y P	<b>MUSULOSKELETAL</b>	
		Bronchitis	Y P	Eating disorder	Y P	Muscle pains	Y P
		Pneumonia	Y P	Last colonoscopy _____		Joint pains	Y P
		Emphysema	Y P	Other: _____		Osteo-arthritis	Y P
<b>EYES:</b>		Tuberculosis	Y P	<b>FEMALE:</b>		Back pain	Y P
Impaired vision	Y P	Central chest pain	Y P	Age of 1 <sup>st</sup> menses _____		Muscle spasms	Y P
Eye pain	Y P	Other: _____		# of days of menses _____		Joint swelling	Y P
Redness	Y P			_____ Length of cycle _____		Broken bones	Y P
Excessive tearing	Y P	<b>CARDIOVASCULAR:</b>		_____ Bleeding b/w _____		Gout	Y P
Dryness	Y P	Rapid heart beat	Y P	periods	Y P	Other: _____	
Double/Blurred vision	Y P	High blood pressure	Y P	Painful periods	Y P	<b>NEUROLOGICAL:</b>	
Spots/floaters	Y P	Chest pain	Y P	Irregular Periods	Y P	Fainting/Black outs	Y P
Flashing lights	Y P	Palpitations	Y P	Excessive flow	Y P	Numbness	Y P
Glaucoma	Y P	Heart murmurs	Y P	PMS	Y P	Tremors	Y P
Cataracts	Y P	Rheumatic fever	Y P	Menopause	Y P	Pins & needles	Y P
Discharge/infection	Y P	Difficult breathing	Y P	Low libido	Y P	Loss of balance	Y P
Other: _____		Leg cramps	Y P	Yeast infections	Y P	Paralysis	Y P
		Thrombophlebitis	Y P	Vaginal Dryness	Y P	Speech problems	Y P
<b>EARS:</b>		Edema/swollen ankle	Y P	Abnormal discharge	Y P	Memory loss	Y P
Impaired hearing	Y P	Cold hands/feet	Y P	Pain with intercourse	Y P	Loss of sleep	Y P
Infection	Y P			Difficulty conceiving	Y P	Nervousness/tension	Y P
Ringing	Y P	<b>GENITOURINARY:</b>		Pregnancy(s) # _____		Irritability	Y P
Dizziness	Y P	Urgency	Y P	Miscarriage(s) # _____		Depression	Y P
Discharge	Y P	Pain on urination	Y P	Abortion(s) # _____			
		Dribbling/leaking	Y P	Endometriosis	Y P	<b>GENERALS:</b>	
<b>MOUTH &amp; THROAT:</b>		Frequency at night	Y P	Uterine fibroids	Y P	Weight loss/gain	Y P
Bleeding gums	Y P	Incontinence	Y P	Ovarian Cysts	Y P	Insomnia	Y P
Sores in mouth	Y P	Burning pain	Y P	Cervical Dysplasia	Y P	Fatigue	Y P
Gum problems	Y P	Urinary tract infections	Y P	Hysterectomy	Y P	Night sweats	Y P
Periodontal disease	Y P	Kidney infections	Y P	Fibrocystic Breasts	Y P	Profuse perspiration	Y P
Thrush	Y P	Kidney stones	Y P	Menopause	Y P	Weakness	Y P
Sore throat	Y P	Reduced urine flow	Y P	Age of onset: _____		Mood Swings	Y P
Enlarged lymph nodes	Y P	STDs (HPV, etc.)	Y P	Last pap smear: _____		Anxiety	Y P
Loss of taste	Y P	Other: _____		Other: _____		Other: _____	
Difficulty swallowing	Y P						
Other: _____							

**Toxicity Exposure**

Do you work in the presence of toxic fumes or chemical?      Y   N  
Do any of your hobbies involve toxic materials?                Y   N  
Are you currently exposed to second hand smoke?               Y   N

**Miscellaneous**

How does your condition affect you? \_\_\_\_\_  
\_\_\_\_\_

What do you think is the root cause? \_\_\_\_\_

What do you feel needs to happen for you to get better? \_\_\_\_\_  
\_\_\_\_\_

What do you enjoy most in your life? \_\_\_\_\_

What would you like to change about your health and/or life ? :  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

What are your health goals? \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

How much change are you willing to make at this time for improving your health?  
MINIMAL            SOME                            COMPLETE

Is there any information about your health you would like to add?  
\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_