



LEAT KUZNIAR, HBSC ND  
Naturopathic Doctor  
(201) 757-5558

## Adult Intake

Name \_\_\_\_\_ Date \_\_\_\_\_

Date of birth \_\_\_\_\_ (M/D/Y) Social Security # \_\_\_\_\_ Sex M F

Address: \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

E-mailAddress: \_\_\_\_\_

Telephone number: Home: \_\_\_\_\_ Work: \_\_\_\_\_

May we leave messages relating to your visits? Y / N

Emergency contact: Name: \_\_\_\_\_

Phone number: \_\_\_\_\_ Relation: \_\_\_\_\_

How did you hear about this Clinic?: \_\_\_\_\_

Please list other health care providers you are seeing:

- |           |           |           |
|-----------|-----------|-----------|
| 1. _____  | 2. _____  | 3. _____  |
| _____     | _____     | _____     |
| _____     | _____     | _____     |
| ( ) _____ | ( ) _____ | ( ) _____ |

Please list your health concerns, in order of importance to you:

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

If you are female, are you currently pregnant? Yes No (Please circle one)

**Medical history**

How would you describe your general state of health (please circle one)?

Excellent Good Fair Poor

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

---

---

---

---

---

---

---

---

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

---

---

---

---

Please list all current medications you are taking (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

---

---

---

---

Please list past prescription medications and approximate dates.

---

---

---

---

Approximately how many times have you been treated with antibiotics? \_\_\_\_\_

Do you frequently use any of the following? (circle the applicable)

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

Alcohol—how often and amount \_\_\_\_\_

Tobacco—form and amount/day \_\_\_\_\_

Caffeine—form and amount/day \_\_\_\_\_

Recreational drugs—form and how often \_\_\_\_\_

Please indicate what immunizations you have had

DPT (diphtheria, pertussis, tetanus)

Haemophilus influenza B

Hepatitis A

Tetanus booster; date? \_\_\_\_\_

"Flu"

Hepatitis B

MMR (measles, mumps, rubella)

Polio

Smallpox

Other \_\_\_\_\_

Please indicate any adverse reactions in response to any of these vaccines: \_\_\_\_\_

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

Do you regularly undergo screening tests? (Physical, pap smear, blood tests, etc.)? Y / N

### Diet

Do you have any food allergies or intolerances? Please list.

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

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

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

Describe a typical day's diet:

Breakfast \_\_\_\_\_

Lunch \_\_\_\_\_

Dinner \_\_\_\_\_

Snacks \_\_\_\_\_

Beverages (type and amount) \_\_\_\_\_

**Family history**

Please indicate whether a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

**Environment**

Occupation \_\_\_\_\_

Hobbies \_\_\_\_\_

Do you exercise regularly? Y / N What type of exercise do you do? What is the duration?  
How often do you exercise?

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

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

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

Please describe. \_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Please describe the emotional climate of your home? \_\_\_\_\_

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

Please approximate the level of daily stress you experience on a scale of 1-10? How well do you believe you handle these stresses? \_\_\_\_\_

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

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

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