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-mail Address:____

Telephone number: Home:_______________________ **Cell/ 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? _______________

In the past year? _____________

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?

____

____

____

Please check all programs in which you have interest:
Detoxification Program (diet, herbs, homeopathic remedies) ☐
Prevention Program (based on familial predispositions or current risk factors) ☐
Weight Loss/ Body Composition Program ☐
Exercise Program ☐
Healthy Eating Program ☐
Stress Management Program/ Biofeedback ☐
Testing for Vitamin/Mineral Deficiencies ☐
Graceful Aging Program ☐
Smoking Cessation Program ☐
Organic Skincare Products ☐
Acupuncture ☐
Massage Therapy ☐
Psychotherapy ☐