Beatty Naturopathic
Dr. Jonathan Beatty N.D.
Adult Intake Form

The information requested below will assist us in treating you safely. Feel free to ask any questions about the information being requested. Please note that all the information provided below will be kept confidential unless permission by you or required by law. Your written permission will be required to release any information.

Today's Date _____

Name_____Birthdate (d)____/(m)____/(y)_____ Age_____

Address _____ City _____ Postal Code_____

Home Phone _____ Cell# _____ Business Phone _____ Ext._____

Email_____ (For office use only.)
❒ I do not wish to receive updates via email.
❒ I do not wish to receive appointment reminders via email.

Height:_____ Weight:_____

How did you hear about this clinic? Name of Person:_____

Emergency Contacts:
1- Name: _____ Home Phone _____
Relation:_____ Bus. Phone _____

2- Name: _____ Home Phone _____
Relation:_____ Bus. Phone _____

Other Health Care Providers: (Attach extra sheets as needed)
1- Name/Address/Contact #/Type of Practitioner: _____
_____

2- Name/Address/Contact #/Type of Practitioner: _____
_____

Primary Health Concern: _____

Location:_____

Onset of concern: _____

Duration of concern: _____

Other areas involved: _____

How often does this occur?: _____

Rate the intensity of the concern (scale of 1-10, 10 being the worst):_____

Briefly describe the concern: _____

Please do not wear perfumes, aftershaves or other scents to the office as some patients are allergic.

Primary Health Concern: (CONTINUED)

Other problems related to concern: _____

Things that relieve problem: _____

Things that make problem worse: _____

Previous treatments for this concern: _____

_____

Secondary Health Concerns Including Treatments Received:

1 - _____

_____

_____

2 - _____

_____

_____

3 - _____

_____

_____

4 - _____

_____

_____

5 - _____

_____

_____

Social History

Alcohol intake: yes [ ] no [ ]; if yes, how often? _____

Smoking: yes [ ] no [ ]; if yes, how often? _____

Recreational drugs: yes [ ] no [ ]; if yes, how often and type? _____

_____

Exercise: yes [ ] no [ ]; if yes, how often and type? _____

_____

Caffeine: yes [ ] no [ ]; if yes, how often? _____

Cravings: _____

Current medications and dose (*include prescription and over-the-counter drugs*):

_____

Current Supplements and dose (include herbs, vitamins, homeopathics etc.):

_____

_____

Any other current medical treatments? (chiropractic, physiotherapeutic, reiki or other)

_____

_____

Have you had any of following:

Hospitalizations? _____

Surgeries? _____

Illnesses? _____

Traumas? _____

Serious conditions? _____

Medications? (include dose) _____

Allergies? _____

Nutrition:

Describe a typical day's diet:
Breakfast:_____

Lunch: _____

Dinner: _____

Snacks: _____

Water intake? _____(# of glasses) Coffee/Tea _____(# of cups)

Drinks (include quantity total for the day) _____

_____

Are there any foods you avoid for personal or religious reasons?_____

_____

Sleep:

How many hours of sleep do you receive in an average night? _____

What time do you go to bed? _____

Do you have trouble falling asleep? Y / N _____

Do you wake during the night? Y / N How often? _____

Do you have nightmares? Y / N How Often? _____

What time do you wake in the morning? _____

Do you wake feeling rested? Y / N _____

Family History:

Has any member of your family had the following (please include relation and time of diagnosis, as well as age of death if illness was the cause):

Health issue	Relation	Age of onset	Health Issue	Relation	Age of onset
Cancer			Diabetes		
Heart Disease			Birth Defects		
Arthritis			Allergies		
Mental Disorders			Epilepsy		
Asthma			Other_____		
Other_____			Other_____		

(M=Mother, F = Father, GM = Grandmother, GF = Grandfather, A= Aunt, U = Uncle, S = Sibling)

Social History:

How much stress do you experience (scale of 1-10, 10 being worst) _____

In an average week, explain how much time is spent on the following activities:

Activity	Time Spent (*hrs*)	Activity	Time Spent (*hrs*)
Exercising		Reading	
Watching televison		Playing video games	
Using a computer		other	

Are there any pets in your home? Y / N Type: _____

Is there any smoking in your home? How often? _____

Is there any drug use in your home? How often? _____

How is your home heated? _____

How old is your home?_____

Have you ever found mould in your house?_____

Are there any other toxins you have been exposed to? _____

How would you describe the emotional climate of your home? _____

_____

Are there any other concerns that you would like to discuss that were overlooked on this form?

_____

_____

_____

What are your treatment goals? _____

_____

_____

Do you have any preferred treatment methods? _____

_____

_____

Please read and sign the following;

I have read and understand that the information given above regarding my past and present health is complete to the best of my knowledge. I acknowledge that the medical information collected will be kept confidential, but may be shared within my circle of care, where the dissemination of medical information is within my best interest for my safety.

A client's care is of utmost priority to us, the time we have set up is of importance to your care; we do need 24 hours notice regarding cancellations, upon missed visits we will have to charge the full fee to recover the lost time.

Name (please print) _____

Signature _____

Date: (YYYY/MM/DD)_____/_____/_____