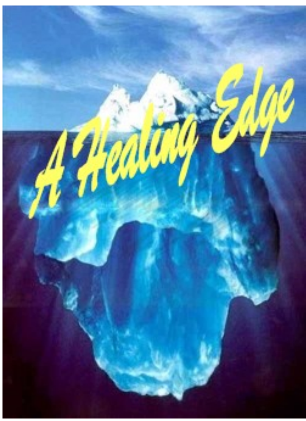

A Healing Edge

David Bellis CHt.

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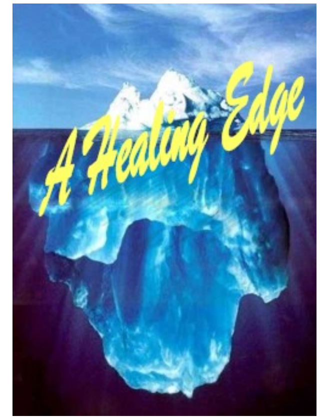

Balanced healing for the body, mind and spirit.

We are aware of the time it takes to fill out such a lengthy intake form. However, your co-operation in completing it is essential in providing the highest standard of care. All information is confidential.
PLEASE PRINT

REGISTRATION INFORMATION

Name: ____e-mail:________________
(First) (Middle) (Last)

Date:________________________________
mm dd yy

Date of Birth: _____/_____/_____ Age: ______ Gender: _______
mm dd yy

Home Address: ____

City: ____________________ Postal Code: ______________

Home Telephone: ( ) ____________ Work: ( ) ____________

May we leave messages on your home phone relating to visits? Y N

How did you find out about my services? ✔ Referral – Whom may we thank? _________________
___Billboard
___Health food store
___Other __________________

Family Physician: __________________Phone: ( ) _______________________

Other Health Care Providers:_________________ Phone:( )_________________

Have you ever been knowingly hypnotized before? ____ yes ____ no

Phobias ____

CHIEF HEALTH CONCERNS

What are your health concerns? (List in order of importance to you):

1. ____
2. ____
3. ____
4. ____
5. ____

List any other concerns you may want to discuss:

____
____
____

If you are female, are you currently pregnant? Y N

MEDICAL HISTORY

How would you describe your general state of health? (Circle)
Excellent Good Fair Poor

Please indicate any serious conditions, illnesses, injuries, and any hospitalizations along with approximate dates:

____
____
____

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

____
____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathic, etc.):

____
____
____

Please list all past prescription medications:

____
____
____

Alcohol – how much / day or week ____
Caffeine – form and amount / day ____
Recreational drugs – what and how often ____

FAMILY HEALTH HISTORY

Indicate if a close relative (parent, child, sibling) has any of the following:

	|Who?		|Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stoke	
Hepatitis		Tuberculosis	
Heart disease		Other	

I don't know my family history.

GENERAL HISTORY

Check the symptoms / conditions which apply to you:

✔ **Generals**
_____ Noticeable weight loss _____ Fatigue _____ Noticeable weight gain
_____ Weakness _____ Fever

✔ **Skin**
_____ Rashes _____ Color change _____ Lumps
_____ Changes in hair / nails _____ Itching _____ Dryness
_____ Eczema _____ Hives _____ Psoriasis
_____ Boils _____Moles

✔ **Head**
_____ Head injuries _____ Headaches
_____ Hair loss _____ Dandruff

✔ **Eyes**
_____ Redness _____ Pots _____ Pain
_____ Specks _____ Excessive tearing _____ Flashing lights
_____ Double vision _____ Glaucoma _____ Blurred vision

_____ Cataracts _____ Crossed eyes _____ Blind spot
_____ Discharge

Do you wear glasses / contacts? _______________________________

Date of last eye exam? ______________________________________

✔ **Ears**

_____ Infection _____ Ringing in the ears (tinnitus) _____ Vertigo
_____ Discharge _____ Earaches _____ Hearing loss

Do you use hearing aids? _____________________________________

Date of last hearing test? ______________________________________

✔ **Nose and Sinuses**

_____ frequent colds _____ Hay fever _____ Nosebleeds
_____ Nasal stuffiness _____ Discharge _____ Itching
_____ Loss of smell _____ Sinus infections

✔ **Mouth and Throat**

_____ Dry mouth _____ Bleeding gums
_____ Sore tongue _____ Hoarseness
_____ Spots / sores in mouth _____ Dental cavities
_____ Heat / cold intolerance _____ Sore throat
_____ Lumps in neck _____ Loss of taste
_____ Tonsillitis _____ Stiff neck
_____ Enlarged thyroid

Date of last dental exam? _______________________________________

✔ **Respiratory**

_____ Sputum _____ Cough
_____ Haemoptysis _____ Bronchitis
_____ Wheezing _____ Emphysema
_____ Asthma _____ Pneumonia
_____ Tuberculosis _____ Pleurisy
_____ Chest pain _____ Difficulty breathing

✔ **Cardiovascular**

_____ Rapid heart beat _____ Slow heartbeat
_____ High blood pressure _____ Heart murmurs
_____ Low blood pressure _____ Rheumatic fever
_____ Chest pain _____ Edema /(Tissue swelling) swollen ankles
_____ Palpitations _____ Difficulty breathing
_____ Blueness of skin (cyanosis) _____ Cold hands / feet
_____ Thrombophlebitis (lack of circulation) _____ Extremity numbness
_____ Deep leg pain _____ Leg cramps

Results of electrocardiogram or other heart tests:

____

____

✓ **Gastrointestinal**

_____ Trouble swallowing
_____ Heartburn
_____ Excessive hunger / thirst
_____ Poor appetite / thirst
_____ Diabetes
_____ Nausea
_____ Vomiting
_____ Regurgitation
_____ Vomiting of blood
_____ Indigestion
_____ Hepatitis
_____ Ulcer
_____ Excessive bloating
_____ Hemorrhoids
_____ Constipation
_____ diarrhea
_____ hypoglycemia (low blood sugar)
_____ abdominal pain
_____ food intolerance / allergy
_____ excessive belching
_____ passing of gas
_____ jaundice
_____ liver or gallbladder problems
_____ colitis
_____ hernias

✓ **Musculoskeletal**

_____ Muscle or joint pains
_____ Arthritis
_____ Back pain
_____ Broken bones
_____ General muscle weakness
_____ stiffness
_____ gout
_____ artificial joints / limbs
_____ muscle spasms / cramps
_____ joint swelling

✓ **Neurological**

_____ Fainting / blackouts
_____ weakness
_____ numbness / loss of sensation
_____ Tremors / involuntary motion
_____ Nervousness
_____ Depression
_____ Difficulties concentrating
_____ Convulsions / seizures
_____ loss of balance
_____ paralysis
_____ tingling / pins and needles
_____ speech problems
_____ tension
_____ memory changes / loss
_____ irritability
_____ loss of sleep/ insomnia

✓ **Hematological**

_____ Anemia
_____ Easy bleeding
_____ any past transfusions
_____ easy bruising

Any other conditions:

____

____

DIET

Do you have any food allergies or sensitivities? Please list:
____
____
____

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

Describe a typical day's diet (with quantity)
Breakfast ____
Lunch ____
Dinner ____
Snacks ____
Beverages ____

LIFESTYLE / ENVIROMENT

Occupation ____

Hobbies ____

Do you exercise regularly? Y N What do you do for exercise, how much and how often?
____
____

Are you exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:
____
____

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

How stressful is your work or other aspects of your life? How do you manage stress?
____
____
____

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

Thank you for taking time to complete this intake form. I look forward to working with you in your naturopathic care. This form provides the means do an evaluation with the given information and also work on your treatment protocol.