Jay Grossman

Chiropractor |Naturopath
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ADULT FEMALE INTAKE FORM

Name________________________________ Age______ Date of Birth_____________ Country of Birth________________________
Address/Postal Code____
Phone(H)________________ Phone(C)_______________ Email____
Preferred method of contact: ____
Occupation_____________________________ Place of Work ____
Past Occupations__________________________________ Emergency Contact Name _____________________________________
Emergency Contact Number____________________________ Relation ____
Marital Status/Living Arrangement____________________ Number of children and ages____________________________ ________
Family Physician______________________ Other Health Care Practitioners____
Have you seen a Naturopathic Doctor before? ____
How did you hear about Dr. Grossman? ____

HEALTH CONCERNS (Please list in order of importance)

1)	2)	3)
4)	5)	6)

MEDICAL HISTORY

Date of last physical exam___________________ Height__________ Weight_________ Blood Type___________________________
Maximum Weight____________ Desired Weight (Explain)____
Current Medications and Dosages (including over-the-counter) ____
____
Past Medications____
How many times have you been treated with antibiotics? ____
Current Vitamins, Minerals, Supplements or Herbal products and Dosages____
____
Do you have any known allergies? ________ To what? ____

Please circle which of the following childhood diseases you have had: Measles German Measles Chicken Pox Mumps Whooping Cough Rheumatic Fever Diphtheria Scarlet Fever Polio Other____
Have you had X-rays in the last 3 years?____
Have you had any other lab testing or medical procedures performed in the last 3 years?_____________________________________

REPRODUCTIVE HISTORY:

Age of first menstrual period:_____ Approx. Cycle length______ Approx. Period length______ Regular PAP tests? ________________
History of Abnormal PAPs? _________ Date of last PAP?__________ Abnormal breast exams/mammograms? _____________________
History of PMS Symptoms (moodiness, cramps, breast tenderness, etc)?
Explain____
____
Have you ever been sexually active? Yes/No; History painful/difficult intercourse? Explain____________________________________
What is your sexual orientation? (circle) Heterosexual Homosexual Bisexual Undecided
Have you ever contracted a sexually transmitted disease? Yes/No; Which Disease(s)? ____
Current method of birth control (if applicable)_________________Past methods____
Number of live pregnancies & Maternal age________________________________ Miscarriages? ______ Abortions? ______________
Menopausal history if applicable (Please give symptoms and ages)____
____

TRAMAS/ ACCIDENTS/ SURGERIES/ DISEASES:
Please list all major accidents, hospitalizations, surgeries, diseases and traumatic events, and your age at the time:

Event	Age	Event	Age
1.		2.	
3.		4.	
5.		6.	
7.		8.	

Please continue on the back of this page if you require additional space.

FAMILY MEDICAL HISTORY (Please check boxes if you or a family member have had the following:)

	You	Mother	Father	Sister/Brother	Grandparents
Alcoholism					
Anemia					
Arthritis (Osteo or Rheumatoid)					
Asthma/Allergies					
Autoimmune Disease (Lupus, etc)					
Cancer (Give type)					
Chronic Fatigue/Fibromyalgia					
Depression/Mood swings					
Diabetes					
Eczema/Psoriasis					
Heart Disease/Angina					
High Blood Pressure					
Kidney Disease					
Osteoporosis					
Schizophrenia/Delusions/Alzheimer's					
Thyroid					
Tuberculosis/Lung Disease					

Other:					
Other:					

NUTRITIONAL HABITS

Please describe a typical day's diet:

Breakfast ____

Lunch ____

Dinner ____

Snacks ____

Beverages (and total quantity) ____

How much water do you drink each day? ____

Please list your favorite foods ____

Do you have food cravings?_______ If so, for what? ___________________________________

Do you drink coffee? ___________ Cups/day? __________ Do you drink Black Tea? ___________Cups/day? ____________________

Do you have any known food allergies or intolerances? _______ To what? ______________________

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

How many bowel movements do you have a day? __________

LIFESTYLE INFORMATION

Do you smoke?_________ How many cigarettes/day?___________ Have you ever used recreational drugs?______________________

Do you drink alcohol?________ How many drinks per day?___________ How many drinks per week?___________________________

Have you ever been treated for an addiction to drugs, alcohol, or prescription medications?______________________________________ How many times per week do you exercise?______ What form of exercise?____ How many hours do you sleep per night?________ Do you have difficulty falling asleep?_______________________________________ How often do you wake through the night?________________

Do you awake in the morning feeling rested?________________________

On a scale of 1-10 (10 is highest) what is your energy like in the (a) morning______ (b) afternoon________ (c) evening_____________

Please list the top three sources of stress in your life: 1)_________________ 2)_________________ 3)__________________________

Do you ever suffer from depression? (Explain)____

Do you ever suffer from mood swings? (Explain)____

Are you/Have you ever been a victim of mental, emotional, or sexual abuse? ______________________

Have you ever had psychiatric/psychological counseling?____________________________________

Do you have unresolved emotional issues or grief? (Explain)__________________________________

____

Do you participate in a Religion/Personal Philosophy?_____________________________________

How content are you with your life? (Explain)____

What would you like to change about your life?____

What do you do in your leisure time?____

What do you do to relax? ____

ENVIRONTMENTAL FACTORS

Do you have any pets?____________________________ Do you have seasonal allergies?____
Are you affected by scented products/perfumes?______________________ Molds?____
Do you live in an apartment?___________________ Basement?______________________ Home?_________________________________
Do you live in a town?________ On a rural street?________ Near/On a farm?___________ Near a golf course?__________________
Approximately what year was your home or dwelling built?_____________ How is it heated?___________________________________
Are chemicals used on your lawn/garden?________________ What is your source of drinking water?______________________________
Are you exposed to any chemicals/hazardous materials on a daily basis?____
How would you describe the emotional climate in your home? ____
____
Can you think of anything in your home/work environment which might adversely affect your health/well-being?
____

Is there anything else that you feel I should know about you?

____
____
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