Jay Grossman

Chiropractor | Naturopath

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ADULT MALE INTAKE FORM

Name_________________________________ Age_____ Date of Birth_____________ Country of Birth_______________________
Address & Postal Code____
Phone(H)____________________ Phone(W)______________________ Cell: ___________________________
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 herbs and dosages____
____
Do you have any known allergies? Y/ N 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? Where? ____
Have you had any other lab testing or medical procedures performed in the last 3 years?_______________________________________

GENITOURINARY/ REPRODUCTIVE HISTORY:
Have you ever been sexually active? Y/N; History painful/difficult intercourse? Explain ______________________________________
What is your sexual orientation? (circle) Heterosexual Homosexual Bisexual Undecided
Have you ever contracted a sexually transmitted disease? Y/N; Which Disease(s)? ____
Have you ever/do you experience painful/difficult urination? _______ Do you wake at night to urinate? __________________________
Have you noticed a change in the direction/force of urinary flow? ______ Have you had your prostate checked manually? ___________
Any abnormalities? _________ Have you had your prostate checked with blood work? _______ Any abnormalities? _____________
Do you have difficulty achieving/maintaining erections? _________ Do you have concerns about your sex drive/libido? ____________
Please list any other concerns: ____

MEDICAL HISTORY: (continued)

Traumas/Surgeries/Accidents/Diseases:
Please list all major accidents, hospitalizations, surgeries, diseases and traumatic events, and your age at the time:
Please continue on the back of this page if you require additional space.

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

FAMILY MEDICAL HISTORY: (Please check boxes if you or a family member have had any of 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 a week do you exercise?______ What form(s) of exercise?____
How many hours do you sleep a night?________ Do you have difficulty falling asleep?____
How often do you wake in the night?________________ Do you wake 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 emotional, physical 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? ____

ENVIRONMENTAL 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?_____________________ House?_____________________________
Do you live in a city?________ Town? ________ A farm/ rural area?___________ 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 YOU FEEL I SHOULD KNOW ABOUT YOU?

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