NC

Dr. Nadine Cyr N.D. – Naturopathic Doctor

## ADULT INTAKE

Name:_____ Age: _____ Date of Birth:_____

Address:_____

(Street) (City) (Postal Code)

Occupation:_____ Employer:_____

Home Phone:_____ Work: _____

e-mail: _____ Cell: _____

Marital Status: S M D W Sep Referred by: _____

### Health Concerns in Order of Importance to You

1) _____ since: _____ prior treatment: _____
2) _____ since: _____ prior treatment: _____
3) _____ since: _____ prior treatment: _____
4) _____ since: _____ prior treatment: _____

### Current (C) and Past (P) Symptoms

__ Sinus Problems
__ Breathing Difficulties
__ Frequent Colds
__ Hay fever
__ Allergies
__ Asthma
__ Cough
__ Bronchitis
__ Pneumonia
__ Strep Throat
__ Alcoholism
__ Anemia
__ Mononucleosis
__ Vision Problems
__ Eye Irritation
__ Diabetes
__ Gout
__ H. Pylori

__ Hyperactivity
__ Learning Disability
__ Headache
__ Nervousness/Anxiety
__ Depression
__ Insomnia
__ Fatigue (am or pm)
__ Dizziness
__ Fainting
__ Seizures
__ Sexual Abuse
__ Chronic Fatigue
__ Chronic Headaches
__ Migraines
__ Spinal Injury
__ Arthritis
__ Thyroid Disorders
Cancer: _____

__ Weakness
__ Concussion
__ Painful Urination
__ Frequent Urination
__ Chronic UTI's
__ Incontinence
__ Kidney Stones
__ Cold Sores
__ Shingles
__ Herpes
__ Hives/Skin rashes
__ Acne
__ Eczema
__ Dry Skin
__ Psoriasis
__ Varicose Veins
__ Poor Circulation

__ Chronic Constipation
__ Diarrhea
__ IBS
__ Crohn's / Colitis
__ Parasites
__ Gall Stones
__ Heartburn / Ulcer
__ Belching / Gas
__ Nausea / Vomiting
__ Hemorrhoids
__ High Blood Pressure
__ Pain over Heart
__ Palpitation
__ Shortness of Breath
__ Stroke
__ Swelling
__ Low Blood Pressure

**Men:**__ Prostate Problems __ Impotency __ Loss of Sexual Desire __ Low Sperm Count

**Women:**__ Painful Menstruation __ Irregular Menstruation __ Tender Breasts __Loss of Sexual Desire __ Fibroids
___Mood Changes __ Hot Flashes __ PCO's __ Miscarriages __ Infertility # of Pregnancies: _____

## Family Health History

Please indicate if any of your immediate relatives now have or have had in the past any of the following conditions? Please note their relationship to you, e.g. mother, father, brother, sister, daughter, etc.

__ Diabetes _____
__ Heart Disease _____
__ Epilepsy _____
__ Mental Disorder _____
__ Alcoholism _____
__ Anxiety _____
__ Thyroid Disorders _____
__ Fibromyalgia _____
__ Cancer _____
__ Allergies _____
__ Asthma _____
__ Genetic Defect _____
__ Depression _____
__ Multiple Sclerosis _____
__ Ulcerative Colitis/ Crohn's _____
__ Osteoporosis _____

| Past Injuries | Past Surgeries |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

**List of Current Supplements:** _____

_____

_____

| Current Medications | Past Medications |
|---|---|
| 1. | 1. |
| 2. | 2. |
| 3. | 3. |
| 4. | 4. |

Do you exercise regularly? Y / N Type of exercise: _____How many days per week: _____
Average # of hours of sleep per night: _____
Do you smoke? Y / N Cigarettes ____ Marijuana ____ Cigars _____ Other: _____
**Number of cups daily of:**
Coffee _____ Decaf Coffee _____ Regular Tea _____ Juice _____ Soda/Pop _____
Do you drink alcohol? Y / N How many drinks per week? _____
Type of alcohol consumed: _____
How many drinks per week? _____

Are you regularly exposed to or handle chemicals, mold, paint fumes, solvents, second hand smoke? _____