Dr. Han Ping Helen Cen, ND 201, 8135 102 St. Edmonton, AB, T6E 4A4
www.drcennd.ca 780-414-1466

Adult Intake Form

Name: _____ Date: _____
Sex:_____ Date of Birth:_____Age: _____Current weight:____Height:_____
Who is filling out this form if not self? (Name and relationship)_____
Address: _____
_____
Phone (Primary): _____(Other):_____
Email: _____
Occupation:_____
Marital status: _____Number of Children:_____
Pregnant? Y/ N If Y, how many weeks:_____ Breastfeeding:_____
Emergency Contact:_____Phone: _____Relation: _____
Name of Medical Doctor:_____Phone:_____
Have you received *naturopathic* care previously?_____
If so, when?_____Name of Practitioner:_____
For what reason?_____
How did you hear of us/who were you referred by:

This is a confidential record of your medical history and will be kept in this office. Information contained in it will not be released to any person unless authorized by you.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees. A receipt will be provided for your private insurance coverage and/or income tax purposes.

Patient's Full Name: _____Date of Consent:_____

Signature of Patient or Lawful Representative:_____

Health Concerns

What are your main health concerns in order of importance to you?

_____
_____
_____
_____

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Vitamins and Supplements

Please list all vitamin/mineral/herbal supplements you are currently taking:
Please bring in all supplements info (or photo) to initial visit

Supplement (including brand)	Dosage	When did you begin this supplement?

Medication

Please list all prescription and non-prescription medications you are currently taking:
*** Please bring in all medications to initial visit***

Medication	Dosage	When did you begin this medication?

Please list all prescription medications you have taken in the past for longer than six months. Indicate how long you took each medication.

Family History

Is there a history of any of the following in your family? Please check and then list relationship of family member beside the condition.

- ☐ Alcoholism
- ☐ Allergies
- ☐ Arteriosclerosis
- ☐ Arthritis
- ☐ Asthma
- ☐ Bed Wetting
- ☐ Candida Albicans
- ☐ Cancer
- ☐ Cataracts
- ☐ Depression
- ☐ Diabetes
- ☐ Epilepsy
- ☐ Heart Disease
- ☐ Hyperactivity
- ☐ Kidney Disease
- ☐ Learning Disability
- ☐ Mental Disease
- ☐ Multiple Sclerosis
- ☐ Celiac
- ☐ Colitis
- ☐ Schizophrenia
- ☐ Tuberculosis
- ☐ Yeast Infections

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Medical History

Please list any injuries and/or major surgery you have had and when they occurred.

_____

_____

_____

_____

Please list any major illnesses or diseases that you have or have had.

_____

_____

_____

_____

Vaccinations (please check)

- DPT (Diphtheria, Pertussis, Tetanus)
- MMR (Measles, Mumps, Rubella)
- Chicken Pox
- Polio
- Flu Shot
- Hepatitis A
- Hepatitis B
- Other

Did you experience any symptoms from them? If yes, please explain.

_____

_____

Diet

- Non Vegetarian
- Vegetarian
- Vegan

For how long?

How many cups/bottles/glasses do you drink, on average, per day?

Coffee	Milk 2%	Fruit juice
Tea	Skim milk	Soft drinks (diet)
Water	Beer	Soft drinks (regular)
Herbal tea	Wine	Vegetable juice
Milk 1%	Liquor	Other

All allergies/intolerances/sensitivities:

_____

_____

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Review of Symptoms

Please check ☑ any of the following that apply to you or write "P" beside the box if you have experienced any in the past.

General

- ☐ Fatigue
- ☐ Change in appetite
- ☐ Change in thirst
- ☐ Bleed or bruise easily
- ☐ Night sweats
- ☐ Allergies
- ☐ Heat or cold intolerance
- ☐ Cancer
- ☐ Sleep problems, hours per night ___
- ☐ Sudden drop in energy (time?)

Skin

- ☐ Rashes/hives/itching
- ☐ Eczema/psoriasis
- ☐ Nail changes (strength/shape)
- ☐ Acne/boils
- ☐ Hair changes (colour/quantity)
- ☐ Changes in skin color
- ☐ Excess dryness/moistness
- ☐ Skin ulcers/skin cancer
- ☐ Warts
- ☐ Recent moles

Head, eyes, ears, nose, and throat

- ☐ Headache
- ☐ Problems with jaw joint/TMJ
- ☐ Head injury
- ☐ Migraines
- ☐ Dizziness
- ☐ Light-headedness
- ☐ Eye pain
- ☐ Blurred/double vision
- ☐ Use of glasses _____ Date of last eye exam
- ☐ Cataract
- ☐ Floaters/blind spot
- ☐ Earache/infection
- ☐ Excess ear wax
- ☐ Ringing in the ears
- ☐ Poor hearing
- ☐ Sinus issues
- ☐ Frequent colds
- ☐ Mercury dental fillings
- ☐ Cold sore/ canker sore
- ☐ Swollen glands

Heart and circulation

- ☐ High blood pressure
- ☐ High cholesterol
- ☐ Heart disease
- ☐ Irregular heartbeat
- ☐ Palpitation/fluttering
- ☐ Chest pain
- ☐ Varicose veins
- ☐ Blood clots
- ☐ Cold hands and feet

Lungs and breathing

- ☐ Shortness of breath
- ☐ Chronic cough
- ☐ Bronchitis
- ☐ Emphysema
- ☐ Asthma
- ☐ Other

Gastrointestinal

- ☐ Heartburn/acid reflux
- ☐ Trouble swallowing
- ☐ Nausea/vomiting
- ☐ Indigestion
- ☐ Blood in stool
- ☐ Gall bladder stones/removal
- ☐ Ulcers
- ☐ Belching/burping/gas
- ☐ Hernia
- ☐ Diarrhea
- ☐ Constipation
- ☐ Black tarry stool
- ☐ Chronic laxative use

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Neurological

- ☐ Fainting/loss of consciousness
- ☐ Seizures
- ☐ Speech problems/slurring
- ☐ History of concussion
- ☐ Loss of sensation
- ☐ Numbness/tingling
- ☐ Twitching
- ☐ Tremors
- ☐ Memory problems

Endocrine

- ☐ Thyroid problems
- ☐ Diabetes
- ☐ Weight gain
- ☐ Weight Loss
- ☐ Hormone replacement therapy

Musculoskeletal

- ☐ Joint pain/stiffness
- ☐ Sciatica
- ☐ Muscle weakness
- ☐ Muscle spasm/cramp
- ☐ Osteoporosis

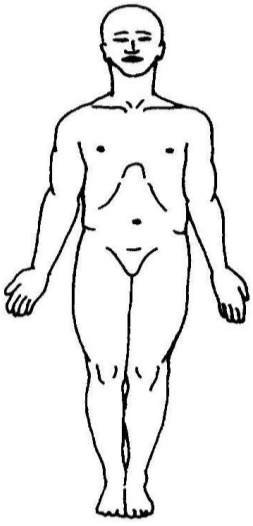
Urinary

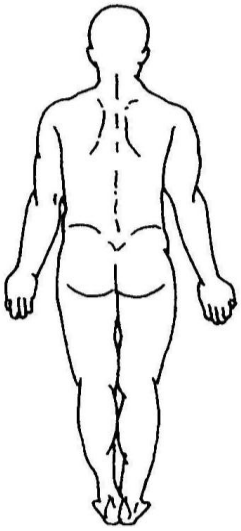
- ☐ Pain/burning while urinating
- ☐ Inability to hold urine
- ☐ Urinary tract infections
- ☐ Blood in urine
- ☐ Urgency/hesitancy
- ☐ Kidney problems
- ☐ Kidney stones/infection

Sexual health

- ☐ Sexually active
- ☐ Contraception use
- ☐ Sexually transmitted infections

Please mark an "X" to indicate areas where you feel pain, swelling or discomfort, or areas of your skin that have changed in color or texture (e.g. moles, rashes, etc.). Describe what you feel or observe in your own words. Write anywhere in this area.





Thank you for taking the time to complete this form to your best knowledge.