

AFSOUN KHALILI BSC, ND
NATUROPATHIC DOCTOR

Adult Intake

(please print clearly)

Name _____ Date _____

Date of birth _____ (Y/M/D) Sex M F

Address: _____

E-mail Address: _____

Telephone number: Home: _____ Work: _____

Mobile/Cell: _____

May we leave messages relating to your visits? Y / N

Emergency contact: Name: _____ Relation: _____

Phone number: _____ Work: _____

Referred by: _____

Other health care providers you are seeing and specialty:

1. _____ 2. _____ 3. _____

(_____) _____ (_____) _____ (_____) _____

What are your health concerns, in order of importance to you:

1. _____

2. _____

3. _____

4. _____

5. _____

If you are female are you currently pregnant? Yes No (Please circle one)

Medical history

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

Please indicate any hospitalizations.

Approximate date Year/month/day	Reason

Please list all **CURRENT** Medications

Medications	Amount per day	Since when? Year/month/day

Please list all **CURRENT** supplements (nutritional, herbal, homeopathics)

Supplement	Amount per day	Since when? Year/month/day

How many times have you been treated with antibiotics? _____

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills or implants

Alcohol—how much per day or week _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

Please indicate what immunizations you have had

DPT (diphtheria, pertussis, tetanus) Haemophilus Hepatitis A

influenza B

Tetanus booster; when? "Flu" Hepatitis B

MMR (measles, mumps, rubella) Pneumovax Polio

Other _____

Please indicate if any caused adverse reactions/what were they?

Do you have any non-food allergies (medicines, environmental, etc.)? Please enumerate.

Diet

Do you have any food allergies/sensitivities or intolerances? Please list.

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

Describe a typical day's diet:

Breakfast

Lunch

Dinner

Snacks

Beverages (and total quantity) _____

Family history

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

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

Environment

Occupation _____

Hobbies -

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

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Are you regularly 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 well do you handle these stresses?

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