Dr. Shannon Ferguson, ND
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Adult Intake

Name: _____ Today's Date: _____
(First) (Last) dd / mm / yy

Date of Birth: ___/___/____ Gender: F M Age: _____
dd/ mm / yy Other:_____
Preferred pronoun:_____

Home Address: _____

Town/ City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____

Email Address: _____

May we leave messages on your home phone relating to your visits? Y N

Emergency contact: _____ Phone:( )_____

How did you find out about our services?
☐ Referral by: _____
☐ Newspaper/ magazine / flyer
☐ Yellow pages
☐ Other _____

Family Physician: _____ Phone:( )_____

Other Health Care Provider(s):
Name: _____ Phone: ( )_____ Name: _____ Phone: ( )_____

Do you have extended medical coverage, if so, what services are covered?
_____

Chief Health Concerns

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

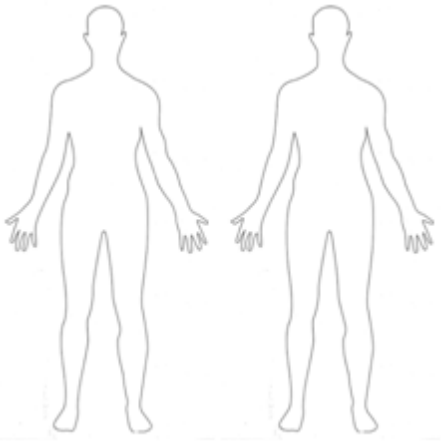
2. _____
3. _____
4. _____
5. _____

List any other concerns you may want to discuss:

_____
_____
_____
_____
_____
_____
_____
_____
_____
_____

Please indicate below any areas of pain:

Front Back



Medical History

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

Have you had any serious conditions, illnesses, injuries, and/or hospitalizations in the past? Please list with approximate dates:

_____
_____
_____
_____

Do you have any allergies (medicines, environmental, foods)?

_____
_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics), with dosage:

_____

_____

(medications continued)_____

_____

Please list any past prescription medications:

_____

_____

Approximately how many times have you been treated with antibiotics in your life?

_____

Do you frequently use any of the following?

☐ Laxatives
☐ Diet pills
☐ Antacids
☐ Aspirin/Tylenol/Advil

☐ Caffeine - form and amount/day_____
☐ Alcohol - how much/day or week_____
☐ Recreational drugs - what and how often_____

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus)
☐ Hepatitis A
☐ "Flu"
☐ MMR (measles, mumps, rubella)
☐ Smallpox
☐ Haemophilus influenza B
☐ Tetanus booster
☐ Hepatitis B
☐ Polio

Please indicate any adverse reactions you may have had to past immunizations:

_____

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) Y N

Diet

Do you have food allergies or intolerance's? Please list:

_____

_____

_____

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

_____

_____

Describe a typical day's diet:

Breakfast _____
Lunch _____
Dinner _____
Snacks _____
Beverages (total amount) _____

Family Health History (√ - currently or 'P' - past):
Indicate if a close relative (parent, grandparent, sibling) has, or has had any of the following:

☐ Allergies	☐ Endometriosis	☐ Osteoporosis
☐ Artificial Heart Valve	☐ Gallstones	☐ PMS
☐ Arthritis	☐ Heart Disease	☐ Rubella
☐ Asthma	☐ High Blood Pressure	☐ Rheumatic Fever
☐ Cancer (type_____)	☐ Kidney Disease	☐ Skin Disease
☐ Diabetes	☐ Mental Illness	☐ Stroke
☐ Eczema	☐ Multiple Sclerosis	☐ Tuberculosis

Any other medical conditions?

_____

_____

_____

Female:

Are you pregnant now? Yes No

Indicate number of occurrences if applicable:
Live births_____ Pregnancies_____ Miscarriages_____ Terminations_____

Age at first period _____ Age at menopause_____

Are your menstrual cycles regular? Yes No

Male:

Do you have any urinary symptoms? Yes No
Describe:_____

_____

Do you get up in the night to urinate? Yes No How often? _____

Environment

Occupation(s)

_____
_____
_____

Hobbies

_____
_____
_____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:

_____
_____
_____

Do you exercise regularly? Y N

What type of exercise, how much, how often?

_____
_____
_____

How would you describe the emotional climate of your home?

_____
_____
_____

How stressful is your work, or other aspects of your life? How do you manage stress?

_____
_____
_____

Is there anything that you feel that is important that hasn't been covered?

_____
_____
_____
_____