Adult Intake Form
Pure Health Wellness Clinic
Leena Kim Naturopathic Doctor
219 Roncesvalles Avenue, Toronto, ON
M6R 2L6, ph: 416-716-7652
leena.kimnd@gmail.com

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

Address:_____
_____
_____

Email Address:_____

Telephone number: Home:_____ **Work**:_____

Emergency contact: _____

Phone number:_____ **Relation**:_____

How did you hear about our Clinic?
_____

Other health care providers you are seeing:
_____
_____
_____
_____

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 serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

_____

_____

Do you have any allergies (medicines, environmental, etc.)?

_____

_____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

_____

_____

_____

_____

Please list past prescription medications.

_____

_____

_____

_____

How many times have you been treated with antibiotics? _____

Do you use any of the following? (circle)

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

Alcohol—how much/day or week

_____

Tobacco— amount/day_____

Caffeine—amount/day_____

Recreational drugs—what and how often_____

Please indicate what immunizations you have had

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

Other

_____

Please indicate if any caused adverse reactions:

_____

_____

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

Date of last medical check up/physical/blood work:_____

Diet

Do you have any food allergies 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 (total daily intake)_____

Family history I don't know my family medical history

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

Please indicate which family member
Allergies
Asthma
Heart Disease
High Blood Pressure
Cancer
Diabetes
Depression
Other Mental Illness
Drug Abuse/Alcoholism
Kidney Disease
Other

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?

_____
_____
_____
_____

Thank you for taking the time to complete this naturopathic intake form.