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## Patient Intake Form

*Please bring any pertinent medical records and all medicines and supplements to your appointment*

Today's date: \_\_\_\_\_

Name: \_\_\_\_\_ Age: \_\_\_\_\_ Date of birth: \_\_\_\_\_ M F

Address: \_\_\_\_\_ City: \_\_\_\_\_ Postal: \_\_\_\_\_

Home Phone #: ( ) \_\_\_\_\_ Work #: ( ) \_\_\_\_\_

Email: \_\_\_\_\_ May we leave a message relating to your visits? Y N

Emergency Contact name, phone #, and relationship to you: \_\_\_\_\_

Your Occupation: \_\_\_\_\_ Satisfied with your work situation? Y N

Who do you live with? \_\_\_\_\_

Name and phone # of other Healthcare providers you are seeing:

1. \_\_\_\_\_ 2. \_\_\_\_\_

**Current Health Concerns**

**What are your chief health concerns?** (Please list them in order of importance to you)

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_

Previous treatments and results: \_\_\_\_\_

**Medical History**

Please check the following that apply to you:

- |                         |                      |               |                        |
|-------------------------|----------------------|---------------|------------------------|
| Cancer                  | Diabetes Mellitus    | Surgeries     | Venereal disease       |
| High blood pressure     | Seizures             | Asthma        | Allergies              |
| Heart disease or stroke | Hepatitis            | Depression    | Other mental illness   |
| Rheumatic fever         | Thyroid disease      | Arthritis     | Alcoholism             |
| Kidney disease          | HIV                  | Drug abuse    | Anemia                 |
| Shingles                | Fibromyalgia         | Ulcer         | Digestive disorders    |
| Neuromuscular disease   | high triglycerides   | Liver disease | Lung/pulmonary disease |
| Osteoporosis            | Gall bladder disease | Miscarriage   | Autoimmune disease     |



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Eating disorders \_\_\_\_\_  
 Serious childhood illnesses \_\_\_\_\_  
 Significant trauma (auto accidents, falls, etc.) \_\_\_\_\_  
 Hospitalizations or surgeries \_\_\_\_\_  
 Other (please specify) \_\_\_\_\_

**Family Medical History** (please write the family member beside checked category, ex. "mother")

Cancer _____	High Blood pressure _____
Asthma _____	Depression _____
Diabetes _____	Heart Disease _____
Allergies _____	Thyroid disease _____
Seizures _____	Stroke _____
Alcoholism _____	Kidney disease _____
Liver disease _____	Hepatitis/jaundice _____
Autoimmune disease _____	Arthritis _____
Colitis/Crohn's disease _____	
Other (please specify): _____	

**Medical and Lifestyle Information**

Date of last physical exam: \_\_\_\_\_ Height \_\_\_\_\_ Weight \_\_\_\_\_ Weight 1 year ago \_\_\_\_\_

Date of last dental check up: \_\_\_\_\_

How would you describe your general state of health?

Excellent      Very Good      Good      Fair      Poor

Energy level (1-10, 10 being the best energy you've ever experienced) \_\_\_\_\_

How many hours of sleep do you get at night? \_\_\_\_\_ Do you wake up feeling refreshed? Y N

Do you wake during the night? Y N If so, at what time(s)? \_\_\_\_\_

Reason for waking during the night? \_\_\_\_\_

Do you drink coffee? Y N #cups/day \_\_\_\_\_

Have you/do you use recreational drugs? Y N

Do you drink alcohol? Y N #drinks/week \_\_\_\_\_

Do you smoke? Y N #cigarettes/day \_\_\_\_\_ How long have you smoked? \_\_\_\_\_

Do you drink pop? Y N #/day? \_\_\_\_\_ Do you use artificial sweeteners? Y N



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How many meals per day do you usually have? \_\_\_\_\_ Do you ever skip meals? Y N

Do you usually snack? Y N If yes, list common snacks \_\_\_\_\_

How many servings of fruit do you consume each day (serving=1 small piece of fruit)? \_\_\_\_\_

How many servings of vegetables do you consume each day (serving=1/2 cup)? \_\_\_\_\_

How often do you eat red meat? \_\_\_\_\_ Poultry? \_\_\_\_\_ Fish? \_\_\_\_\_

What type of oils or spreads do you use? \_\_\_\_\_

How much water do you drink in a typical day? \_\_\_\_\_

Describe your weekly exercise (# of times/week and description of exercise):  
 \_\_\_\_\_  
 \_\_\_\_\_

What do you value in your life?  
 \_\_\_\_\_

How important is spirituality in your life? \_\_\_\_\_

**Please circle the number that indicates your level of stress**  
 (0= no stress, 5= moderate stress, 10= extremely stressful)

Financial	0	1	2	3	4	5	6	7	8	9	10
Job Related	0	1	2	3	4	5	6	7	8	9	10
Home life	0	1	2	3	4	5	6	7	8	9	10
Marriage	0	1	2	3	4	5	6	7	8	9	10
Family	0	1	2	3	4	5	6	7	8	9	10
Health	0	1	2	3	4	5	6	7	8	9	10
Spiritual	0	1	2	3	4	5	6	7	8	9	10
Other	0	1	2	3	4	5	6	7	8	9	10

What are the major stressors in your life?  
 \_\_\_\_\_

Please list all your current prescription medications:  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Please list all vitamin/mineral/herb supplements you are currently taking and indicate dosage:  
 \_\_\_\_\_



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Do you regularly use any of the following : aspirin /tylenol antacids laxatives diet pills

How many times have you been treated with antibiotics in the last 5 years? \_\_\_\_\_

Are you regularly exposed to toxins or other hazards (work, home, hobbies)? \_\_\_\_\_

Do you use conventional or natural household cleaning products? \_\_\_\_\_

Do you have mercury amalgams? If so, how many do you have? \_\_\_\_\_

Have you ever had significant radiation exposure? \_\_\_\_\_

Do you have any known allergies or sensitivities (environmental, medicine, seasonal, pets, etc.). If yes, what are they? \_\_\_\_\_

Do you have any food allergies or intolerances? Please list:  
 \_\_\_\_\_

Do you have any dietary restrictions? \_\_\_\_\_

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

**Check off any of the following if they are a CURRENT or RECURRING symptom:**

<b>General</b>
----------------

- |                           |                         |                           |
|---------------------------|-------------------------|---------------------------|
| Change in appetite        | Night sweats            | Excess energy             |
| Cravings                  | Chills                  | Sudden decrease in energy |
| Excessive appetite        | Fevers                  | Afternoon energy drop     |
| Poor appetite             | Excessive sweating      | Fatigue                   |
| Weight gain (unexplained) | Feel colder than others | Poor sleep quality        |
| Weight loss (unexplained) | Feel warmer than others | Insomnia                  |
| Nausea/vomiting           | Can not tolerate heat   | Difficulty falling asleep |
| Excess thirst             | Can not tolerate cold   | Dream a lot               |
| Frequent colds            |                         |                           |
| Bleed or bruise easily    |                         |                           |

<b>Skin, Hair, Nails</b>
--------------------------

- |                                |             |                            |
|--------------------------------|-------------|----------------------------|
| Change in hair or skin texture | Acne        | Hair loss                  |
| Unusual dryness                | Warts       | Dandruff                   |
| Itching                        | Ulcerations | Excess body or facial hair |



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Rashes	Recent moles/growths	Lines on nails
Eczema	Skin Cancer	Brittle nails
Psoriasis	Sores/wounds do not heal well	Nail fungus
Hives		

### Head, Eyes, Ears, Nose, and Throat (HEENT)

Headaches	Ear aches/infections	Dental cavities
Head or neck problems	Discharge from ears	Teeth problems
Concussions	Poor hearing	Bleeding gums
Migraines	Ringing / buzzing in ears	Jaw clicks/TMJ
Facial pain	Hearing aid	Loss of taste
Eye strain	Vertigo/dizziness	
Glasses	Nose bleeds	
Colour blindness	Chronic sinus problems	
Blurry vision	Nasal stuffiness	
Cataracts	Recurrent sore throats/throat irritation	
Night Blindness	Lump in throat or neck	
Eye pain	Dry mouth or throat	
Eye redness/dryness/itch	Swollen neck glands	
Glaucoma	Enlarged thyroid	
Change or loss in vision	Persistent hoarseness	
Eye floaters (spots before eyes)	Sores on lips, tongue, mouth	

### Respiratory

Difficulty breathing	Asthma	Coughing up blood
Pain with a deep breath	Bronchitis	Production of mucus
Shortness of breath	Pneumonia	Sputum/phlegm (what colour?)
Wheezing	History of smoking	
Chronic/bothersome cough		

### Cardiovascular

High blood pressure	Heart disease	Cold hands or feet
Low blood pressure	Heart murmur	Swelling of hands or feet
Dizziness/fainting	Arteriosclerosis	Poor circulation
Palpitations	Pace maker	Varicose veins
Irregular heart beat		Cramps in legs when walking
Chest pain or tightness		History of blood clots/phlebitis
Difficulty breathing (with exertion, lying down, or during sleep)		

### Gastrointestinal

Indigestion/heart burn	Nausea	Laxative use
Frequent burping	Vomiting	Constipation
Bad taste in mouth	Stomach pain or cramps	Diarrhea
Bad breath	Gas	Alternating constipation/loose stool
Dental problems	Parasites	Rectal pain, burn, itch



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Trouble swallowing	Hemorrhoids
Recent change in eating habits	Anal fissure
Bloating after eating or drinking	Colitis, Crohn's, or IBS
Abdominal discomfort better or worse after eating	Colon polyps
Foods that cause a problem: _____	
Recent change in bowel habits (please describe): _____	
Colour of stool: _____	
Stool floats	Blood in stool / black stool
Very thin stool	Stool breaks up in water

**Genito-urinary**

Frequent urination	Pain/burning on urination
Urinate large amounts of clear liquid	Frequent urinary tract infections
Wake at night to urinate _____ times	Blood in urine
Bedwetting	History of Kidney stones
Urgency to urinate	History of venereal disease
Unable to hold urine/leakage	Sores on genitals
Lose urine when cough, sneeze, or laugh	Itching of genitals
Difficulty urinating/trouble beginning urination	Sexual preference: _____
Dribbling / decrease in force of stream	
Urine is dark and scanty	

**Musculoskeletal**

Neck pain	Muscle pain	Spinal curvature
Hand/wrist pain	Muscle weakness	Osteoporosis/osteopenia
Arm/shoulder pain	Gout	Osteoarthritis
Low back pain	Fractures	Joint stiffness/swelling
Other back pain	Hernia	
Hip pain	Sciatica	
Knee pain	Herniated disk	
Foot/ankle pain		
Other joint or bone problems (please describe): _____		

**Neuropsychological**

Loss of balance	Fainting	Frequently irritable
Lack of coordination	Tremors	Anger/quick temper
Frequent falls	Speech problems	Mood swings
Weakness of arms or legs	Frequent or severe headaches	Susceptible to stress
Paralysis	Concussion or severe head trauma	Under unusual amount of stress lately
Areas of numbness/tingling	Memory loss	Anxiety
Seizures/epilepsy	Insomnia	Depression
Dizziness		



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**Male**

- |                          |                               |                           |
|--------------------------|-------------------------------|---------------------------|
| Problems with prostate   | Concern about growth on penis | Infertility concerns      |
| Testicular mass          | Discharge from penis          | Impotency                 |
| Testicular pain/swelling |                               | Sexual concerns           |
|                          |                               | Difficulty with erections |

**Gynecology and Pregnancy**

- Are you pregnant? Y N    What is the first day of your last period? \_\_\_\_\_
- Age of first menstrual period \_\_\_\_\_ Age of last menstrual period \_\_\_\_\_
- Length of cycle \_\_\_\_\_ days    Periods last \_\_\_\_\_ days
- Have you ever had a mammogram? \_\_\_\_\_
- Date of last PAP smear \_\_\_\_\_ Normal cells    Abnormal cells
- Type of birth control at present \_\_\_\_\_
- Use of oral contraceptives/birth control pill. For how long? \_\_\_\_\_
- Number of pregnancies \_\_\_\_\_ Number of miscarriages \_\_\_\_\_ Number of abortions \_\_\_\_\_
- Number of premature births \_\_\_\_\_ Number of cesarean sections \_\_\_\_\_
- |   |                                     |
|---|-------------------------------------|
| Regular menstrual cycle                         | Migraines with or before periods    |
| Irregular menstrual cycle                       | Depression with or before periods   |
| Heavy flow                                      | Mood swings before periods          |
| Light flow                                      | Food cravings before periods        |
| Cramping or backache w/ periods                 | Bloating/weight gain before periods |
| Endometriosis                                   | Breast tenderness                   |
| Ovarian cysts                                   | Fibrocystic breasts (lumps)         |
| Fibroids  | Nipple discharge                    |
| Clots   | Sexual concerns                     |
| Vaginal discharge                               | Painful intercourse                 |
| Vaginal sores                                   | Low sex drive                       |
| Vaginal itching                                 | Hysterectomy                        |
| Abnormal bleeding                               | Hot flashes                         |
| Fertility problems                              |                                     |
| Complicated pregnancies                         |                                     |
| Menopause (please describe any symptoms): _____ |                                     |



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**Other comments**

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

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What goals do you have for your health care at this time? (symptom relief, achieving optimal health, etc.) :

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