DR. DIANA SEMJONOV
naturopathic doctor

Medical Intake Form

An accurate health history is important to ensure that it is safe for you to receive treatment. If your health status changes in the future, please let us know. All information gathered for treatments is **confidential** except as required or allowed by law to facilitate diagnosis (assessment) or treatment. You will be asked to provide written authorization for release of any information.

Name:_____Age: _____Date of Birth: _____Gender: _____
Address: _____
Occupation:_____Email:_____ May we contact you by email? ☐ Yes ☐No Tel: _____ Physician's Name:_____ Tel:_____
Physician's Address: _____
Emergency Contact Name: _____Relationship:_____ Tel:_____
Date of last visit to any health practitioner: _____How did you hear about us:_____
Main reason for coming in today?_____
_____
_____

When was the very first time you noticed your condition?

How long has your main health problem been troubling you?

Please describe any factors you suspect may have played a role in the onset and its continuation.

Is your current health problem getting better, worse or the same?

Describe any treatments you received for this problem:

_____

Have you ever been to a naturopathic physician? ☐ Yes ☐No

Please list other health concerns and/or goals, in order of importance:

1) _____
2) _____
3) _____

What is the general state of your health? ☐ Excellent ☐Good ☐ Average ☐ Fair ☐ Poor

Please state any sources of stress in your life: _____

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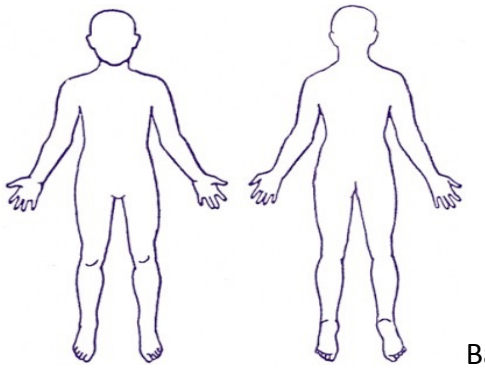
How would you currently rate your energy levels: Low 0 –1—2—3—4—5—6—7—8—9—10--High

Are you, or may you be Pregnant? ☐ Yes ☐No

Are you currently working with any other health practitioner for your health concerns? Please specify.

_____

Please circle any areas in which you experience pain:



Front Back

☒ Which of the following conditions have you experienced?

☐ measles	☐ epilepsy	☐ thyroid problems	☐ weight problems	☐ HIV
☐ polio	☐ insomnia	☐ hepatitis	☐ whooping cough	☐ cancer
☐ tuberculosis	☐ chicken pox	☐ rheumatic fever	☐ scarlet fever	☐
☐ canker sores	☐ typhoid fever	☐ pneumonia	☐ tonsillitis	☐
☐ herpes	☐ ear infections	☐ chronic infections	☐ gonorrhea	☐

Review of systems

Please circle if you are currently experiencing or have experienced in the past any of the following:

C = currently experiencing **P** = past

General			Gastrointestinal			Respiratory		
P	C	Headaches	P	C	Constipation	P	C	Asthma
P	C	Migraines	P	C	Diarrhea	P	C	Emphysema
P	C	Fatigue	P	C	Abdominal bloating	P	C	Persistent cough
P	C	Fever	P	C	Abdominal pain	P	C	Chronic bronchitis
P	C	Sweats	P	C	Gas	P	C	Shortness of breath
P	C	Heat intolerance	P	C	Heartburn	P	C	Excessive phlegm production
P	C	Cold intolerance	P	C	Undigested food in stool	P	C	Spitting up blood
P	C	Dizziness	P	C	Belching	P	C	Smoker
P	C	Fainting	P	C	Change in appetite	Musculoskeletal		
P	C	Poor/disturbed sleep	P	C	Nausea/Vomiting	P	C	Muscle pain
P	C	Recent weight change	P	C	Colitis	P	C	Muscle weakness

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P	C	Numbness/tingling	P	C	Crohn's	P	C	Muscle spasms/cramps
P	C	Allergies	P	C	IBS	P	C	Jaw pain
P	C	Seizures	P	C	Hemorrhoids	P	C	Spinal curvature
			P	C	Hernia	P	C	Swollen joints
Eyes, Ears, Nose, Throat, Mouth			Skin			P	C	Joint stiffness
P	C	Ear infections	P	C	Hives/Allergy	P	C	Bursitis
P	C	Ringing in the ears	P	C	Acne	P	C	Tendonitis
P	C	Deafness	P	C	Eczema	P	C	Gout
P	C	Vertigo	P	C	Psoriasis	P	C	Joint pain, if so where?_____
P	C	Ear discharge	P	C	Itching	Mental Emotional		
P	C	Eye pain	P	C	Bruises easily	P	C	Depression
P	C	Eye infections	P	C	Varicose veins	P	C	Anxiety or Nervousness
P	C	Failing vision	P	C	Warts	P	C	Anger
P	C	Glaucoma	P	C	Change of mole	P	C	Eating disorder
P	C	Cataracts	P	C	Skin Dryness	P	C	Phobias
P	C	Mercury tooth fillings	P	C	Fungal infections	P	C	Psychiatric issues
P	C	Gum disease	Kidneys and Reproductive			P	C	Drug Abuse
P	C	Frequent colds and flus	P	C	Inability to control urine	P	C	Thoughts of suicide
P	C	Recurrent strep throat	P	C	Frequent urination	P	C	Psychological counselling
P	C	Sinus infection	P	C	Urination during the night	P	C	Difficulty focusing
P	C	Sore throat	P	C	Urinary tract infections	P	C	Irritability
P	C	Hoarseness	P	C	Painful urination	P	C	Feeling overwhelmed
P	C	Cold sores	P	C	Blood in urine	P	C	Poor memory
P	C	Head injury	P	C	Kidney infection	Sleep		
Cardiovascular			P	C	Kidney stones	P	C	Difficulties falling asleep
P	C	Palpitations	P	C	Sores in genitals	P	C	Difficulties staying asleep
P	C	Chest pain	P	C	PMS	P	C	Waking unrefreshed
P	C	Elevated cholesterol	P	C	Inability to conceive	P	C	Excessive dreaming or nigthmares
P	C	High or low blood pressure	P	C	Endometriosis			
P	C	Previous heart attack	P	C	Hysterectomy			
P	C	Irregular heart beats	P	C	STDs			
P	C	Ankle or Hand swelling	P	C	Pregnancy			
P	C	Poor circulation	P	C	Bleeding between periods			
P	C	Cold hands and/or feet	P	C	Irregular cycles			
P	C	Shortness of breath	P	C	Menopausal symptoms			
P	C	Anemia						

Have you had any illnesses not listed? If yes, please specify: _____

Have you had any previous hospitalizations, surgeries or injuries? If yes, please specify:

_____

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Do you have any allergies to any drugs, herbs, food, animals or other? ☐ Yes ☐No

Do you use any of the following? Please indicate how much and how often:

Alcohol:
Coffee:
Tobacco:
Antacids:
Painkillers (Advil, Tylenol, Aspirin,etc):
Sedatives:
Hormones:
Laxatives:
Cortisone:
Recreational drugs:

List any medications and/or supplements you are currently taking:

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____

How many times have you been treated with antibiotics? If so, for what condition?

_____

Family History

Please indicate if any family have had any health problems - diabetes, high blood pressure, cardiovascular disease, cancer, mental health conditions, etc.:

	Living Age	Health Problems	Cause of death
Mother			
Father			
Siblings			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

General diet: ☐ Vegetarian ☐ Vegan ☐ Omnivore ☐ Lacto-Ovo ☐ Other_____

What did you have to eat in the last 24 hours? Breakfast_____
Lunch_____Dinner_____

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Snacks _____Beverages (type and quantity)_____

Do you have any food cravings? _____

Is there any additional information that you would like to add?

_____

_____

+Consent to Treatment:

I attest that the information provided on this form is correct to the best of my knowledge, and I consent to the treatment as I understand it. I understand that I am free to ask questions, and that I may withdraw my consent at any time.

Signature: _____ Date: _____