ZAWADA HEALTH

Adult Intake Form

Welcome to Zawada Health, where the health of your family is our priority. Offering the services of Naturopathic Doctors, Registered Massage Therapists, a Psychotherapist, an Osteopathic Athletic Therapist, an infrared sauna and a full product dispensary, we develop customized wellness plans for each member of your family. Using traditional wisdom and modern research, we strive to provide you with safe and effective solutions that fit your lifestyle.

Name: _____
(Last) (First) (Preferred name)

Sex: ❒ Male ❒ Female Age: _____

Height: _____ Weight: _____ Max Weight: _____ When? _____

Please list your chief health concerns in order of importance:

1. _____
2. _____
3. _____

Please list all medications (prescription, over-the-counter) and natural products (vitamins, herbs, oils) currently taking.

Medication/Natural Product (please indicate brand where applicable)	Dose /quantity per day	Why are you taking this product?

Have you ever used any of the following?

❒ Antibiotics for more than 2 weeks
❒ Cortisone or other steroids
❒ Chemotherapy/radiation
❒ Antacids
❒ Antihistamines
❒ Pain relievers (aspirin, ibuprofen)
❒ Drugs for arthritis (Vioxx, Celebrex)
❒ Hormone therapy (including fertility treatments)
❒ Thyroid medication
❒ Laxatives or stool softeners
❒ Blood thinners
❒ Anti-depressants
❒ Stimulants
❒ Diuretics
❒ Flu vaccination
❒ Vaccination for foreign travel
❒ Anesthesia
❒ Sleeping pills or sedatives
❒ Epidural
❒ Recreational drugs

Have you ever experienced adverse effects or an allergic reaction to any of the above products/therapies?

❒ No ❒ Yes, specify _____

Please list any allergies or sensitivities (food/environmental, medications) you currently have or have had previously.

1. _____
2. _____
3. _____
4. _____

Please list all hospitalizations, surgeries and/or major injuries you have experienced.

Description	Year	Outcome/complications?

Please check off any condition(s) you currently or have previously experienced.

- ❒ Acne
- ❒ Anemia
- ❒ Angina/heart attack
- ❒ Appendicitis
- ❒ Arthritis
- ❒ Asthma
- ❒ Bleeding disorder
- ❒ Cancer
- ❒ Cervical dysplasia
- ❒ Chicken pox
- ❒ Chronic bronchitis
- ❒ Crohn's
- ❒ Diabetes
- ❒ Ectopic pregnancy
- ❒ Eczema
- ❒ Emphysema
- ❒ Endometriosis
- ❒ Enlarged prostate
- ❒ Epilepsy
- ❒ Gallstones
- ❒ Glaucoma
- ❒ Gonorrhea
- ❒ Gout
- ❒ Head injury
- ❒ Headaches/migraines
- ❒ Heart disease
- ❒ Hemorrhoids
- ❒ Hepatitis
- ❒ High blood pressure
- ❒ High cholesterol
- ❒ HIV
- ❒ Hives
- ❒ HPV
- ❒ Kidney disease
- ❒ Kidney stones
- ❒ Lupus
- ❒ Measles
- ❒ Memory loss
- ❒ Meningitis
- ❒ Mental illness
- ❒ Miscarriage
- ❒ Mononucleosis
- ❒ Multiple sclerosis
- ❒ Nasal polyps
- ❒ Nerve damage
- ❒ Osteoporosis
- ❒ Parasites
- ❒ Pelvic inflammatory disease
- ❒ Pleurisy
- ❒ Pneumonia
- ❒ Polycystic ovaries
- ❒ Psoriasis
- ❒ Rheumatic fever
- ❒ Rubella
- ❒ Scarlet fever
- ❒ Sickle cell anemia
- ❒ Sexual transmitted diseases
- ❒ Strep throat
- ❒ Stroke
- ❒ Syphilis
- ❒ Thalassemia
- ❒ Tuberculosis
- ❒ Ulcerative Colitis
- ❒ Varicose veins
- ❒ Whooping cough

REVIEW OF SYSTEMS

Please check off any condition(s) you currently or have previously experienced:

Endocrine

- ❒ 20 lbs change in weight
- ❒ Generally feel hot
- ❒ Generally feel cold
- ❒ Sluggish after coffee
- ❒ Poor concentration
- ❒ Hypoglycemia (low blood sugar)
- ❒ Sluggish after eating
- ❒ Mental dullness

Have you recently lost or gained weight? ❒ Yes ❒ No how much? _____ (circle one)

Rate your stress level (1=relaxed, 10=stressed) 1 2 3 4 5 6 7 8 9 10

Rate your energy level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10

How many hours of sleep do you get a night? _____

Do you sleep soundly or is your sleep disrupted? _____

Do you wake feeling rested? _____

Immune

- ❒ Chronic infections
- ❒ Frequent antibiotics
- ❒ Cold sores
- ❒ Swollen glands or lymph nodes
- ❒ Slow wound healing
- ❒ Frequent sore throats
- ❒ Poor childhood immune health

Neurologic/Musculoskeletal

- ❒ Paralysis
- ❒ Numbness
- ❒ Joint pain
- ❒ Loss of balance
- ❒ Muscle cramps or spasms
- ❒ Muscle weakness
- ❒ Tingling
- ❒ Loss of memory
- ❒ Vertigo or dizziness

Skin, Hair and Nails

❒ Rashes
❒ Lumps or abscesses
❒ Excessive perspiration
❒ Dry skin
❒ Warts
❒ Itching
❒ Change in colour
❒ Strong body odor
❒ Hair loss
❒ Change in size, shape or colour of a mole or freckle
❒ Night sweats
❒ Brittle nails

How many times have you had a sunburn? _____

Head, Ears, Eyes, Nose, Throat

❒ Headaches
❒ Migraines
❒ Ringing in ears
❒ Earaches
❒ Impaired hearing
❒ Itchy ear canal
❒ Cataracts
❒ Colour blindness
❒ Visual disturbances
❒ Poor night vision
❒ Far-sighted
❒ Near-sighted
❒ Dry eyes
❒ Nose bleeds
❒ Post nasal drip
❒ Runny nose
❒ Poor sense of smell
❒ Loss of smell
❒ Gum problems
❒ Hoarseness
❒ Jaw pain and clicking
❒ Teeth grinding
❒ Breathe through your mouth

Respiratory System

❒ Chronic cough
❒ Shortness of breath lying down
❒ Chronic phlegm
❒ Pain while breathing
❒ Cough up blood
❒ Shortness of breath during the day
❒ Wheezing
❒ Asthma
❒ Pneumonia

Cardiovascular System

❒ Chest pain
❒ Hemorrhoids
❒ You feel dizzy when you stand up quickly
❒ Fainting
❒ Heart palpitations
❒ Easy bleeding or bruising
❒ Cold hands and feet
❒ Heaviness or pain in legs
❒ Varicose veins
❒ Heart murmurs
❒ Socks leave imprints on your ankles

Gastrointestinal System

❒ Trouble swallowing
❒ Nausea
❒ Blood in stools or on tissue
❒ Mucous in stools
❒ Stool floats in bowl
❒ Heartburn
❒ Bloating
❒ Itching around anus
❒ Change in thirst
❒ Stomach cramps or pain
❒ Gas
❒ Constipation
❒ Black stools
❒ Undigested food in stools
❒ Change in appetite
❒ Burping
❒ Diarrhea or loose stools
❒ Hard stool
❒ Grey stool

How often do you have a bowel movement? _____

Have you ever travelled to a third-world country? ❒ Yes ❒ No

If so, please specify where and for how long? _____

Have you ever had parasites that you are aware of? _____

Urinary System

❒ Pain on urination
❒ Frequent bladder infections
❒ Strong urine odour
❒ Inability to hold urine
❒ Kidney infections
❒ Increased frequency
❒ Wake up to urinate
❒ Must strain to urinate

Men's Health (if applicable)

❒ Hernia
❒ Discharge or sores
❒ Testicular mass
❒ Sexual difficulties
❒ Testicular pain
❒ Impotence
❒ Low sex drive
❒ Prostate condition

Are you sexually active? ❒ Yes ❒ No

When was your last prostate exam? _____

Women's Health (if applicable)

❒ Fibrocystic breasts
❒ Puckering of skin around nipple
❒ Nipple discharge
❒ Breast tenderness
❒ Flaky or dry skin on nipple
❒ Breast lumps or cysts

Do you perform monthly self breast examinations? ❒ Yes ❒ No

When was your last clinical breast exam? _____

When was your last mammogram? _____

Age of first menses _____
Age of last menses (if applicable) _____
How long is your cycle (in days)? _____
When was your last menstrual period? _____
Are you sexually active? _____

Number of pregnancies? _____
Are you currently pregnant? _____
If so, how many months/weeks? _____
Are you trying to conceive? _____

What type of birth control do you use (if any?) _____

❒ Discharge
❒ Itching
❒ Abdominal pain mid cycle
❒ Vaginal dryness
❒ Abnormal pap tests
❒ Sexual difficulties
❒ Sores, growths or lumps
❒ Odour
❒ Pain during intercourse
❒ Menopausal symptoms
❒ Abortions
❒ Miscarriages
❒ Low sex drive
❒ Use tampons

When was your last pap test? _____

❒ Pain or cramping
❒ Clotting
❒ Diarrhea
❒ Water retention
❒ Irregular cycles
❒ Missed periods
❒ Bloating
❒ Breast tenderness
❒ Heavy flow
❒ Bleeding between periods
❒ Cravings
❒ Light flow
❒ Mood Swings
❒ Headaches
❒ Low back pain

Mental/Emotional

❒ Abuse
❒ Anxiety or nervousness
❒ Depression
❒ Easily angered
❒ Indecision
❒ Irritability
❒ Memory problems
❒ Mental illness
❒ Mood swings
❒ Panic attacks
❒ Phobias
❒ Prolonged sadness or grief

What are the three major contributors to stress in your life?

1._____
2._____
3._____

Has there been an illness or event in your life that you feel you have never fully recovered from? If so, please specify.

_____
_____

Lifestyle

Are you currently or have you ever been a smoker? ❒ Past ❒ Never ❒ Currently

If so, how many packs a day? _____

How long have you smoked or when did you quit? _____

Are you exposed to second hand smoke? ❒ Yes ❒ No

Do you use recreational drugs? i.e. marijuana ❒ Yes ❒ No

If yes, please specify type and frequency of use _____

How much time do you spend outdoors per week? _____

How often do you exercise? _____

What kind of exercise do you do? _____

What do you do to relax? _____

Describe your support network. _____

Describe your living situation. _____

Do you have a spiritual practice? ❒ Yes ❒ No

Toxin Exposure

Have you ever been exposed to mold, solvents, lead paint, heavy metals, fumes or other toxic substances at home (hobbies, renovations), at work or while traveling? ❒ Yes ❒ No

Have you ever experienced health problems after putting down new carpeting, painting renovations or having your lawn sprayed with herbicide? ❒ Yes ❒ No

Are you particularly sensitive to perfume, gasoline or other vapor? ❒ Yes ❒ No

Have you ever lived near a refinery or a polluted area? ❒ Yes ❒ No

Have you ever lived in a home more than 50 years old? ❒ Yes ❒ No

Do you have mercury dental fillings? ❒ Yes ❒ No

Have you had any dental root canal procedures? ❒ Yes ❒ No

Do you have any surgical implants? (cosmetic, medical) ❒ Yes ❒ No

Do you live near power lines? ❒ Yes ❒ No

Diet

How much water do you drink per day? _____

How many times per week do you eat red meat? _____

How many times per week do you eat fish? _____

How often do you eat out/order in? _____

What foods do you crave? _____

Do you eat smoked foods? ❒ Yes ❒ No

Do you have any dietary restrictions? ❒ Yes ❒ No
If so, please specify. _____
(e.g. vegetarian, vegan, religious, allergies)

Family Health History

	Age (or age at death)	Health Concerns
Mother		
Father		
Sisters		
Brothers		
Grandparents		

Is there anything you feel is important to note that has not been covered in this questionnaire?

_____

_____

_____

_____

Thank you for answering all the questions.
Complete answers to all of the questions are to your benefit for the most effective naturopathic treatment.

This is a confidential record of your medical history and will be kept in this office. Information contained here will not be released to any person except when you have authorized us to do so.