

Dr. Andrew Lustig, ND

CLIENT INTAKE FORM - ADULT

Name: _____

Mailing Address: _____

Telephone (home): _____ (work): _____ Email: _____

Date of Birth: _____ Age: _____ Male [] Female []

Family/ Home Status: (single, live with friends, married, single parent, etc.)

Height: _____ Weight: _____ Blood Type: _____

Family Doctor/Past Naturopathic Doctor: _____

phone: _____

Chiropractor: _____ phone: _____

Other Health Care Provider (please specify what treatment they provide):

Emergency Contact Person: _____

Relation: _____ Phone (home): _____ (work): _____

Known Diseases: _____

Known Allergies: _____

Please state why you have chosen a Naturopathic

Direction: _____

Chief Health Concerns (In order of importance):

1. _____

2. _____

3. _____

4. _____

5. _____

Detailed history of your primary health concern (onset, pertinent dates and procedures if any): _____

Referred to us by: _____

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Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset, or unusual stress in your life?

Explain. _____

In regards to your chief complaint, please list what treatments, diets, and therapies, if any, have brought improvement or relief?

Have you had any major relationship changes in the last two years?

Have you had any major employment changes in the last two years?

Have you had any deaths in the family or of close friends in the last two years? _____

Do you use any of the following?

⊖ Organic Food amount (diet percentage): _____

⊖ Refined Sugar amount/type: _____

⊖ Red Meat amount/type: _____

⊖ Coffee or Black Tea amount: _____

⊖ Tobacco # daily: _____

⊖ Soda Pop/ soft drinks amount: _____

⊖ Liquor / Beer / Wine amount: _____

⊖ Antacids/etc amount: _____

⊖ Margarine type: _____

⊖ Processed Foods type: _____

⊖ Recreational Drugs type: _____

⊖ Laxatives type: _____

⊖ Aspartame # products daily: _____

Do you exercise? (Include type, frequency, duration, and intensity):

Do you have a problem with addiction: yes [] no []

Type: Food [] Alcohol [] Drugs [] Other: _____

Hours a day you spend: Working: ____ Sleeping: ____ Watching TV: ____

In front of the Computer: ____ Commuting or in the car : ____

Recreation (not TV): ____ Doing something you love: ____

What is your STRESS LEVEL (10 = High Stress)

1 2 3 4 5 6 7 8 9 10

What is your main stressor? _____

How would you describe your daily mood and energy? _____

List all the Food Supplements, Vitamins, Health Products, and Prescription Drugs you are currently taking. Use the other side of this sheet and note here if needed. Product Dosage Why Since When.

Have you had any of your organs surgically removed? Which one(s)?

List any significant traumas you have lived through. (Car accident, injuries, surgery...)

What was your childhood like? _____

Context of Care

What 3 expectations do you have from your first visit?

1) _____

2) _____

3) _____

What long-term expectations do you have from working with me?

Cancellation Policy/Other Terms:

Please ensure to provide 2 business days cancellation notice. For appointments cancelled on the same day, full cost of the appointment will be charged.

Please sign that you have read and agree to the cancellation policy and other terms as written above, on the website below and in the [legal disclaimer](#):

Signature: _____ Date: _____

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