

Patient Intake Form

Dr. Colin Huska, ND

General Information

Date: _____ Name: _____
Last First Initial

Age: _____ Date of Birth: _____
Day/Month/Year

Address: _____

City: _____ Province: _____ Postal Code: _____

Phone - Home: _____ Cell: _____ Business: _____

Email: _____ Can messages be left confidentially? Y N

Gender (circle one): Male Female Marital status: _____

Occupation: _____

Medical Doctor: _____

Date of last physical exam: _____ Blood tests done? Y N

How did you find out about the clinic? _____

Emergency Contact

Name: _____ Relation to you: _____ Phone: _____

General Intake

What is your main reason for coming in today?

List in order of importance other health problems that are troubling you:

1. _____ Length of Time: _____
2. _____ Length of Time: _____
3. _____ Length of Time: _____
4. _____ Length of Time: _____

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What kind of conventional treatment have you received? _____

Have you ever seen a: (please circle all that apply)

Naturopathic Doctor Chiropractor Acupuncturist Massage Therapist Osteopath

Other? _____

Current Medications (please list dosage)

1. _____

2. _____

3. _____

4. _____

5. _____

Nutritional Supplements (please list dosage)

1. _____

2. _____

3. _____

4. _____

5. _____

Please list the five most significant stressful events in your life:

1. _____ Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

5. _____ Date: _____

Are you currently working with a professional counselor, psychologist, social worker or therapist? Y N

Have you in the past? Y N When? _____

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Past Medical History: Which conditions do you have now (N) or in the past (P)

	N	P		N	P		N	P		N	P
Allergies			Weight problems			Stroke			STI/STD		
Asthma			Gallstones			Cancer			HIV/AIDS		
Eczema			Gout			Epilepsy			Reflux		
Psoriasis			Arthritis			Migraine			Miscarriage		
Ear infections			Thyroid problems			Pneumonia			Varicose veins		
Strep throat			Anemia			Diabetes			High Cholesterol		
Hay fever			High blood pressure			Malaria			Numbness/tingling		
Measles			Rheumatic fever			Tuberculosis			Cold hands/feet		
Mumps			Fainting			Small pox			Visual problems		
Chicken pox			Poor memory			Polio			Warts		
Whooping cough			Balance problems			Yeast infections			Mono		
Eye infections			Speech problems			Gas/bloating			Depression		
Scarlet fever			Ringling in ears			Hemorrhoids			Child abuse		
Sinusitis			Jaundice			Parasites			Physical abuse		
Canker sores			Hepatitis			Rectal bleeding			Sexual abuse		
Acne			Heart disease			Herpes			Emotional abuse		
Tonsillitis			Alcoholism			Headaches			Rape		

Do you have any specific allergies? Y N

Please List: _____

Have you had any major injuries? Y N

If yes, please explain: _____

Have you had previous surgeries or hospitalizations? Y N

If yes, please explain: (include dates if known): _____

In your opinion, what is your weakest system (e.g. digestive, immune, cardiovascular, etc.)? _____

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Family History: please indicate who, if anyone, is dealing with the following conditions in your family

	Mother	Father	Sister/Brother	Grandparents
Cancer				
T.B.				
Heart Disease				
Arthritis				
Diabetes				
High Blood Pressure				
Asthma				
Kidney Disease				
Depression				
Anemia				
Alzheimer's				
Parkinson's				
Multiple Sclerosis				
Lupus				
Celiac Disease				
Other				

Vaccination

Have you been vaccinated? Y N

Any adverse reactions? _____

Other Activities

Which of the following do you currently use? (please list how much, how often)

Alcohol _____ Tobacco _____

Coffee _____ Hormones _____

Laxatives _____ Sedatives _____

Antacids _____ Cortisone _____

Recreational drugs (please specify) _____

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What do you enjoy most in life? _____

What are your main interests and hobbies? _____

What do you worry most about in life? _____

What nurtures you? _____

Do you have a religious/spiritual practice? _____

Do you exercise? Y N

If so, what do you do? _____

How would you rate the quality of your sleep? _____

Do you have troubles falling or staying asleep? _____

How many hours of sleep do you get per night? _____ How many do you feel you need? _____

Do you nap or rest during the day? _____

How would you describe your energy? _____

Are you sexually active? Y N Are you experiencing a loss in sexual desire? Y N

Sexual orientation (please circle one): Heterosexual Bisexual Homosexual Transgendered

Do you use birth control? Y N If so, what form? _____

Female

Age of first menses: _____ If periods have stopped, age at which they did so: _____

Have you had a partial or complete hysterectomy? Y N

Are your cycles regular? Y N Periods begin every _____ days, and last _____ days.

Are your periods: heavy medium light What color is the blood? _____

Are there any clots? Y N

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Premenstrual symptoms: _____

Number of pregnancies? _____ Live Births? _____ Miscarriage? _____ Abortion? _____

Have you had any difficulty getting pregnant? Y N

Do you get regular PAPs? Y N Any abnormal findings? Y N

If so, results? _____

Do you do regular self breast exams? Y N

Have you had: Endometriosis Fibroids Ovarian cysts Fibrocystic breasts

Male

How often do you get up at night to urinate? _____ Has this number changed? Y N

Do you have difficulty (circle one if applies): achieving an erection maintaining an erection

Do you have any: sores on the penis? Y N Abnormal discharge? Y N

Do you have or have a history of venereal disease? Y N

If so, which one(s)? _____

Do you have prostate problems? Y N

Have you had your prostate examined? Y N When? _____

Digestion

How would you describe your digestion? _____

How frequently do you have a bowel movement? _____

Any history of (circle all that apply) :

gas bloating diarrhea constipation blood in stool undigested food black stools strong odor

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Musculoskeletal

Do you have muscle aches and pains? Y N

If so, where? _____

Do you have joint aches and pains? Y N

If so, where? _____

Does this interfere with your daily activity? Y N Is this due to an accident/injury? Y N

Environment

Is your home damp or moldy? Y N Do you have specialized air filtration at home? Y N

Do you live/work in the city? Y N Do you work in an office building? Y N

Do the windows open? Y N Are you exposed to toxic materials? Y N

Do you smoke or are you exposed to second hand smoke? Y N

What do you use as drinking water? Tap Bottled Filtered Reverse osmosis

Is there anything else you feel I should know? _____

Thank you for filling out this lengthy questionnaire!