Dr Ayla Wilson ND

Adult Naturopathic Intake Form

Personal Information

Name _____ Date of First Visit _____
Address _____
City _____ Province _____ Postal Code _____
Telephone # (home)_____ (work)_____
E-mail Address _____ Relationship Status _____
Age _____ Date of Birth (M/D/Y)_____ Gender: female ____ male ____
Occupation _____Hours per week _____ Employer_____
Has any other family member already been a patient at the clinic? _____
Next of kin or other to reach in an emergency _____
Relationship _____ Phone _____
How did you hear about Dr. Wilson? _____

Health Overview

Name of current general practitioner (MD) _____
GP's contact information _____
When was your last visit to your GP? _____
What was the reason? _____
Are you seeing a medical specialist? Y N
If yes, for what reason? _____
Name of medical specialist _____
Do you have any known contagious diseases at this time? Y N If yes, what?_____
What is the main reason for your visit today?_____
_____
What are your most important health concerns? List as many as you can in order of importance.

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

Consent Policy

I hereby consent to receive treatment by Dr. Ayla Wilson, ND. I understand that Dr. Ayla Wilson is a licensed Naturopathic Physician providing nutritional and lifestyle counseling, acupuncture and traditional oriental medical care, naturopathic spinal manipulations, botanical/herbal medicine, homeopathic medicine, Bowen technique, and intravenous/intramuscular injections.

Cancellation Policy

I understand that I am solely responsible for paying the full cost of treatment if I do not give 24 hours notice of change or cancellation.

Email Correspondence

*Please note that I will not sell, rent, or share your email address

Yes / No I would like to receive free newsletters from Dr. Ayla Wilson, ND

Yes / No Dr. Ayla Wilson ND may correspond with me at the above email address if necessary

Signature: _____

(Parent or Guardian if patient is a minor)

Health History

Family History

Mother's side _____

Father's side _____

Ethnicity _____

Past Medical History

Have you had any major illnesses, accidents, hospitalizations or surgeries?

_____ year: _____ _____ year: _____

Have you had any X-rays, CAT scans, EEG's or EKG's?

_____ year: _____ _____ year: _____

Allergies + Sensitivities

Drugs: _____

Foods: _____

Environmentals or Chemicals: _____

What are the symptoms you experience?

_____

Anaphylaxis? Yes / No

Medications + Supplements

Please list any prescription or over the counter medications you are currently taking:

1) _____ 3) _____
2) _____ 4) _____

Please list any naturopathic remedies (herbal, vitamin/mineral, nutritional, homeopathic, etc) you are currently taking:

1) _____ 5) _____
2) _____ 6) _____
3) _____ 7) _____

4) _____ 8) _____

General Health

Height _____ Weight _____ lbs. Weight 1 year ago _____lbs.
Max Weight _____ lbs. When _____
Min Adult Weight _____ lbs When _____
When during the day is your energy the best? _____ worst? _____

Review of Systems

*Circle any of the following conditions that you have currently or have had in the past

Lifestyle

Current / Past	Alcohol use; # of drinks per week?_____
Current / Past	Marijuana use
Current / Past	Other recreational druns; Specify?_____
Current / Past	Smoking; # packs per day? _____ # of years? _____
Current / Past	Treated for drug dependence
Current / Past	Stress
Current / Past	Occupational hazards
Current / Past	Any major traumas

Mental / Emotional

Current / Past	Treated for emotional issues	Current / Past	Difficulty Concentrating
Current / Past	Mood swings	Current / Past	Depression
Current / Past	Anxiety or nervousness	Current / Past	Considered / Attempted suicide

Endocrine

Current / Past	Hypothyroid	Current / Past	Seasonal depression
Current / Past	Hypoglycemia (low blood sugar)	Current / Past	Excessive hunger
Current / Past	Excessive thirst	Current / Past	Diabetes
Current / Past	Fatigue	Current / Past	Heat or cold intolerance

Immune

Current / Past	Reaction to vaccine	Current / Past	Frequent colds/flus
Current / Past	Chronic swollen glands	Current / Past	Slow wound healing
Current / Past	Chronic or recurrent infection		

Neurologic

Current / Past	Seizures	Current / Past	Loss of memory
Current / Past	Tremors	Current / Past	Vertigo or dizziness
Current / Past	Muscle weakness	Current / Past	Difficulty sleeping
Current / Past	Numbness or tingling		

Skin

Current / Past	Rashes	Current / Past	Night sweats
Current / Past	Acne / boils	Current / Past	Perpetual hair loss
Current / Past	Color change	Current / Past	Itching
Current / Past	Lumps	Current / Past	Hives
Current / Past	Eczema		

Head

Current / Past	Headaches	Current / Past	Head injury
Current / Past	Migraines	Current / Past	Jaw / TMJ problems

Mouth + Throat

Current / Past	Frequent sore throats	Current / Past	Jaw clicks
Current / Past	Teeth grinding	Current / Past	Hoarseness
Current / Past	Gum problems	Current / Past	Sore tongue / lips
Current / Past	Dental cavities	Current / Past	Excessive or deficient saliva

Eyes

Current / Past	Blurry vision	Current / Past	Recent changes in vision
Current / Past	Impaired vision	Current / Past	Infection
Current / Past	Color blindness	Current / Past	Tearing or dryness
Current / Past	Cataracts	Current / Past	Eye strain
Current / Past	Glasses or contacts	Current / Past	Eye pain

Ears

Current / Past	Impaired hearing	Current / Past	Impaired balance
Current / Past	Earaches	Current / Past	Ringing in the ears

Nose + Sinuses

Current / Past	Sinus problems	Current / Past	Loss of smell
Current / Past	Stuffiness or post-nasal drip	Current / Past	Hayfever
Current / Past	Nose bleeds		

Neck

Current / Past	Lumps	Current / Past	Pain or stiffness
Current / Past	Goiter	Current / Past	Swollen glands

Respiratory

Current / Past	Cough	Current / Past	Bronchitis
Current / Past	Spitting up blood	Current / Past	Pleurisy / Pleuritis
Current / Past	Asthma	Current / Past	Difficulty breathing

Current / Past	Pneumonia	Current / Past	Shortness of breath
Current / Past	Emphysema	Current / Past	Shortness of breath on lying down
Current / Past	Pain on breathing	Current / Past	Shortness of breath at night
Current / Past	Sputum	Current / Past	Wheezing

Cardiovascular

Current / Past	Heart disease	Current / Past	Angina / Chest pain
Current / Past	High or Low blood pressure	Current / Past	Murmurs
Current / Past	Blood clots	Current / Past	Fainting
Current / Past	Phlebitis	Current / Past	Palpitations/ Fluttering
Current / Past	Rheumatic fever	Current / Past	High cholesterol
Current / Past	Swelling in the ankles		

Gastrointestinal

Current / Past	Trouble swallowing	Current / Past	Constipation
Current / Past	Reflux	Current / Past	Change in bowel movements
Current / Past	Heartburn	Current / Past	Abdominal pain/cramps
Current / Past	Vomiting blood	Current / Past	Gallbladder disease
Current / Past	Nausea	Current / Past	Black stools
Current / Past	Change in appetite	Current / Past	Colon polyps
Current / Past	Ulcer	Current / Past	Jaundice
Current / Past	Hemorrhoids	Current / Past	Liver disease

Urinary

Current / Past	Pain on urination	Current / Past	Frequency at night
Current / Past	Increased frequency	Current / Past	Inability to hold urine (Urgency)
Current / Past	Frequent infections	Current / Past	Kidney stones

Musculoskeletal

Current / Past	Joint pain or stiffness	Current / Past	Arthritis
Current / Past	Broken bones	Current / Past	Weakness
Current / Past	Muscle spasms or cramps	Current / Past	Sciatica
Current / Past	Ligament or joint injury		

Blood + Peripheral Vascular

Current / Past	Easy bleeding or bruising	Current / Past	Anemia
Current / Past	Deep leg pain	Current / Past	Cold hands / feet
Current / Past	Varicose veins	Current / Past	Thrombophlebitis

Female Reproductive + Breasts

Age of first menses _____ Length of cycle _____
Duration of Menses _____ Age of last menses (if menopausal) _____

Date of last annual exam/ PAP (M/D/Y) _____
Date of last mammogram (if applicable)_____

Current / Past	Irregular cycles	Current / Past	Abnormal Pap
Current / Past	Bleeding between cycles	Current / Past	Cervical dysplasia
Current / Past	Cramping with menses	Current / Past	Endometriosis
Current / Past	Premenstrual syndrome (PMS)	Current / Past	Ovarian cysts
Current / Past	Clotting	Current / Past	Uterine fibroids
Current / Past	Heavy or excessive flow	Current / Past	Sexually active
Current / Past	Vaginal discharge	Current / Past	Painful intercourse
Current / Past	Menopausal symptoms	Current / Past	Sexual difficulties
Current / Past	Breast lumps	Current / Past	Sexual transmitted infection
Current / Past	Breast pain / tenderness	Current / Past	Birth control: Type_____
Current / Past	Nipple discharge	Current / Past	Difficulty conceiving

Number of pregnancies _____ Number of live births _____
Number of miscarriages _____ Number of abortions _____
Do you do breast self exam? _____ Have you had a hysterectomy?_____

Male Reproductive

Current / Past	Hernias	Current / Past	Sexually transmitted infection
Current / Past	Testicular masses	Current / Past	Discharge or sores
Current / Past	Testicular pain	Current / Past	Impotence
Current / Past	Prostate disease	Current / Past	Premature ejaculation
Current / Past	Sexually active	Current / Past	Birth control: Type_____
Current / Past	Difficulty conceiving		

What expectations do you have from this visit to our clinic?

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

What expectations do you have of me as your physician?

Thank you for your time in providing this information.