Zepp Wellness

healing, naturally.

ADULT INTAKE FORM (AGES 13 AND OVER)

Full Name: _____

Date of birth (dd/mm/yyyy): _____ Age: _____ Sex: M F

Full address: _____

Email address: _____

Telephone: (home) _____ (work) _____(cell) _____

May we leave messages relating to your visits? Y / N

Emergency Contact: _____ (____)_____

Full Name Relation Telephone

Name of Medical Doctor: _____ Tel: (_____)_____

Date of last visit to a Medical Doctor: _____ Date of last physical: _____

Other health care providers you are seeing:

1. _____ 2. _____ 3. _____

_____ _____ _____

_____ _____ _____

(____)_____ (____)_____ (____)_____

Extended Health Care Carrier (if applicable): _____

How or by whom were you referred to this clinic? _____

Have you been treated by a Naturopathic Doctor (ND) before? Y N

If yes, by whom? _____ When? _____

Health Concerns

What is your primary health concern?

_____

_____

How long have you had this condition? _____

What specialist(s) have you seen, if any?

_____

_____

How has this condition been treated until now?

_____

_____

Can you trace the origin of the present illness to any particular circumstances, accident, illness, incident, mental upset or unusual stress in you life? If yes, please explain.

_____

_____

Additional Health Concerns and Health Goals

What else would you like to see changed in your health? List all other health concerns or goals in order of importance to you. Indicate the month and year each particular health concerned started, if possible.

	Health Concern/Goals	Month/Year	Present Treatment/Comments
1			
2			
3			
4			
5			

How would you describe your general state of health? Excellent Good Fair Poor

How long has it been since you experienced excellent health? _____

Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remains as a weak point in our body's system. Homeopathic medicine takes into account details of the past and will work to eliminate these weak points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

_____
_____
_____
_____

Medical History

Please list past prescription medications.

_____
_____
_____

Approximately how many times have you been treated with antibiotics? _____

In the lists below, please review the symptoms. Leave blank if the symptom does not apply to you, otherwise 1 to 3 if you are currently experiencing the symptom (1-rarely; 3-severe).

Symptom	*Score*		
Sensitive to cold	1	2	3
Constipation	1	2	3
Chronic fatigue	1	2	3
Depressed, apathetic	1	2	3
Sugar causes irritability and mood swings	1	2	3
Low sex drive	1	2	3
Swollen puffy eyes	1	2	3
Thick ridged fingernails	1	2	3
Dry skin	1	2	3
Muscle pain or stiffness	1	2	3
Excessive menstrual bleeding	1	2	3
Thinning/ loss of outer portion of eyebrow	1	2	3
Hair loss, dry hair	1	2	3
Gain weight easily	1	2	3
TOTAL			

Symptom	*Score*		
Feel tired in the afternoon	1	2	3
Dizziness/ loss of vision on standing quickly	1	2	3
Low blood pressure	1	2	3
Cannot tolerate much exercise	1	2	3
Itchy, red, inflammed eyes	1	2	3
Dark circles under eyes	1	2	3
Eyes sensitive to bright light	1	2	3
Sensitive to exhaust fumes, smoke, smog	1	2	3

Periodic constipation alt. diarrhea	1	2	3
Depression or rapid mood changes	1	2	3
Unrefreshed sleep	1	2	3
Catch cold easily when weather changes	1	2	3
Salt cravings	1	2	3
Ringing in the ears	1	2	3
TOTAL			

Symptom	*Score*		
Need exercise to keep going	1	2	3
High or low blood pressure	1	2	3
OK while moving; crash when stop	1	2	3
Lightheaded on standing quickly	1	2	3
Unrefreshed sleep	1	2	3
Use of stimulants	1	2	3
Crave sugar/ salt	1	2	3
Tension in muscles of shoulders/ calves	1	2	3
Difficulty regulating temperature	1	2	3
Eyes sensitive to bright light	1	2	3
Sensitive to exhaust fumes, smoke, smog	1	2	3
Ringing in the ears	1	2	3
TOTAL			

Symptom	*Score*		
Crave sweets	1	2	3
Headaches relieved by eating sweets or alcohol	1	2	3
Often feel shaky or jittery	1	2	3
Have times of feeling faint	1	2	3
Irritable if a meal is missed	1	2	3
Feel tired or weak if a meal is missed	1	2	3
Feel very tired 1 to 3 hours after eating	1	2	3
Calmer after eating	1	2	3
Wake in the night feeling anxious	1	2	3
Wake up in middle of night craving sweets	1	2	3
Heart palpitations after eating sweets	1	2	3
Need to drink coffee to get started	1	2	3
Impatient, moody, nervous	1	2	3
Tend to "bonk" with prolonged exercise	1	2	3
Thirst	1	2	3
TOTAL			

Symptom	*Score*		
Many "appliances" in bedroom – phone, TV, DVD, computer, alarm clock, etc	1	2	3
Watch TV, work on computer until just before bed	1	2	3
Work on computer immediately upon rising	1	2	3
Feel unrefreshed in the morning	1	2	3
Need caffeine to get you going	1	2	3
Dream about work	1	2	3
Wake in night with difficulty falling back asleep, particularly in the early morning hours	1	2	3
Self or partner snores	1	2	3

Wake with a dry mouth	1	2	3
Dream disturbed sleep	1	2	3
On anti-depressants			3
Tendency to eat meals late at night	1	2	3
Eyes feel tired/ dry	1	2	3
Tension in jaw	1	2	3
TOTAL			

Symptom	*Score*		
Wake in the night, between 1 and 3 AM	1	2	3
No appetite in the morning	1	2	3
Use alcohol to unwind	1	2	3
Eat many meals at restaurants	1	2	3
Socialize frequently	1	2	3
Crave stimulants – alcohol, caffeine, chocolate	1	2	3
Crave salty or fatty foods – deep fried, potato chips	1	2	3
Smoker			3
High cholesterol and/or high triglycerides	1	2	3
Difficulty digesting fats	1	2	3
High toxin exposure (occupational/ cleaning products/ second hand smoke)	1	2	3
Headaches/ irritability	1	2	3
Digestive disturbances/ abdominal pain	1	2	3
Joint/ muscle ache	1	2	3
TOTAL			

Symptom	*Score*		
You have been rejected from giving blood on even ONE occasion			3
You are female			3
You are a runner and run > 40 km/ week	1	2	3
You feel weak or lightheaded	1	2	3
Vegetarian or vegan diet			3
Gas/ Intestinal bloating	1	2	3
Strong smeeling gas/ stool	1	2	3
Heavy feeling after meals	1	2	3
Dark circles under eyes	1	2	3
Day long fatigue/ poor concentration	1	2	3
Exercise makes you feel week	1	2	3
Leg muscles tire easily	1	2	3
Cold hands/ feet	1	2	3
Brittle nails/ hair	1	2	3
TOTAL			

Symptom	*Score*		
Breathlessness	1	2	3
Day long fatigue	1	2	3
Use of antacids	1	2	3
Dizziness	1	2	3
Confusion	1	2	3
Rapid, weak pulse	1	2	3
Palpitations	1	2	3
Tinnitus			3

Nerve pain/ numbness	1	2	3
Headaches	1	2	3
Family history of heart disease	1	2	3
Personal history of heart medication usage	1	2	3
Vegan diet			3
Difficulty digesting meat	1	2	3
TOTAL			

Symptom	*Score*		
Score 1 for <4 fruits per day; 2 for < 3 fruits per day; 3 for <2 fruits per day	1	2	3
Score 1 for <4 veggies per day; 2 for < 3 veggies per day; 3 for <2 veggies per day	1	2	3
You eat more than one serving of processed grain product per day (bread, muffin, cereal)	1	2	3
Low water intake	1	2	3
Use of antacids	1	2	3
Use of coffee or black tea	1	2	3
Use of soda pop	1	2	3
Eat meals out at restaurants	1	2	3
Eat meals while working/ on the run	1	2	3
Consume packaged/ processed foods	1	2	3
Consume non-organic foods	1	2	3
Consume dairy products	1	2	3
Once started eating, difficult to stop	1	2	3
High appetite	1	2	3
TOTAL			

In the list below, check all surgeries or traumatic events you have experienced

Surgeries, Please check	√	Surgeries, Please check	√	Trauma	√
Tonsils		Uterus		Serious shock	
Abdomen		Penis		Serious grief	
Heart		Prostate		Major	
Appendix		Cataract		Disappointments	
Hernia		Brain		Severe fright	
Hemorrhoids		Cancer		Nervous Breakdown	
Joint Replacement		Anesthesia		Period of stress	
Kidney Stones		Other:		Overload	
Gall Stones		Other:		Other:	

Please list all of the medical tests you have received in the past:

Please check	√	Please check	√
Complete physical		Prostate exam (males)	
ECG (Electrocardiogram)		PSA test (males)	
Hemoccult (Stool blood)		Bone density screen	

Cardio stress test		PAP smear (females)	
Colon exam		Breast exam	
MRI		Mammogram	
X-rays		Other	

Please list all immunizations that you have received (if known):

_____

_____

Was there any serious reaction to any of the above vaccinations? (please explain)

_____

_____

Dental Work

How many mercury (silver colored) amalgam fillings do you have? _____

How many root canals? _____

Have you had any silver amalgams removed? Y N If yes, when _____

Family History

Please put an "L" for living and "D" for deceased, and present age or age at the time of death.

Relationship	L/D	Age	Diseases Suffered/ Cause of Death
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			
Father			
Mother			
Brother			
Brother			
Sister			
Sister			
Paternal Uncles			
Paternal Aunts			
Maternal Uncles			
Maternal Aunts			

Personal Profile

Height: _____ Present weight: _____ Goal weight: _____

If your present weight is different than your desired weight, how long has it been since you were your normal or goal weight? _____

Marital status: _____How long have you been married (if applicable)? _____

Number of Children (if applicable): _____

List any of the foods you crave (e.g. chocolate, sweets, salty, breads, rice, fatty or spicy foods, etc.):_____

_____

Do you tend to be thirsty? Y / N
Do you prefer beverages: Hot / Cold / Room Temperature?

What is the source of your drinking water?
Tap (city) ☐ Well ☐ Bottled (spring) ☐ Filtered ☐ Distilled ☐

Do you use any of the following? (circle)

Laxatives / Antacids
Diet pills
Birth control pills/implants/injections
Aspirin/ Tylenol/ Advil—how much/day or week _____
Alcohol—how much/day or week _____
Tobacco—form and amount/day _____ past? _____
Caffeine—form and amount/day_____
Recreational drugs—what and how often_____

Have you ever had a problem with an addiction? If yes please specify.
Food _____ Alcohol _____ Drugs _____
Other _____

How many hours of sleep do you get on average? _____
Do you feel refreshed in the morning? Y N

Occupation: _____
Do you like your work? Y N
If No, why not? _____
How many hours do you work each day? _____
Do you often feel overworked? Y N

What do you do for exercise? (indicate frequency, intensity and duration)

_____

_____

_____

What do you do for recreation?

_____

_____

How would you describe your present level of personal stress? Please circle

0	1	2	3	4	5	6	7	8	9	10
None										Extremely high

Dietary Habits

Diet: Non Vegetarian □ Vegetarian □ Vegan □ For how long? _____

Do you have any food allergies or intolerances? Please list.

_____

_____

_____

Describe a typical day's diet:

Breakfast _____

Lunch_____

Dinner_____

Snacks _____

Beverages (and total quantity) _____

On the average, describe your energy level:

0	1	2	3	4	5	6	7	8	9	10
None										Extremely high

At what time of the day is your energy highest?_____ Lowest?_____

Thank you for taking the time to fill out this questionnaire.
It will help greatly in my study of your present health concerns,
and in my understanding of your health goals.
Your responses will assist me in choosing the appropriate treatment that will
Hopefully bring about your return to optimal health.