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: _____

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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