



Dr. Walter Fernyhough, ND
Confidential patient intake form

Date: _____

Legal name: _____ Age: _____ D.O.B.: _____

Preferred name: _____ Sex: **F M**

Address: _____ Postal code: _____

Home phone: _____ Business phone: _____ Cellular phone: _____

Status: **Married Single Widowed Separated Divorced Common law Same sex**

Medical doctor: _____

Emergency contact: _____ Relationship: _____ Phone: _____

How did you hear about this clinic? _____

Current health status

What health concern(s) brought you in to this office? _____

Any recent changes? _____

What have you tried so far and what have been the results? _____

Please list any other health related concerns (incl. allergies). _____

Height: _____ Weight: now _____ 1 yr ago _____ Maximum _____

Smoker? **Y N Past** Amount: _____

Alcohol? **Y N Past** Amount: _____

Coffee? **Y N Past** Amount: _____



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Past Medical history (personal) – please circle any that apply

- | | |
|---------------------------------------|------------------------------|
| Anemia | Hay fever |
| Arthritis | Headaches |
| Asthma/Bronchitis | Head injury |
| Bladder/urinary problems | Heart problems |
| Bleeding problems | Hepatitis |
| Blood pressure problems | Hypoglycemia |
| Cancer | Joint problems |
| Colitis | Kidney problems |
| Colds, flu, or sore throats (chronic) | Liver problems/Jaundice |
| Diabetes | Lung problems |
| Digestive problems | Mononucleosis |
| Ear problems | Osteoporosis/Osteopenia |
| Eating disorder | Parasites |
| Edema | Psychological difficulties |
| Epilepsy | Sexually transmitted disease |
| Eye problems | Sinus problems |
| Fatigue (chronic) | Skin problems |
| Gynecological problems | Stroke |
| Fever | Throat problems |
| Gall bladder problems | Thyroid problems |
| Gum/Teeth problems | Toxic exposure |
| Gout | Ulcer |

Family Medical History (not personal) – please indicate which relative

- | | |
|--------------------------------|------------------------------------|
| Anemia _____ | Hay fever _____ |
| Arthritis _____ | Headaches _____ |
| Asthma/Bronchitis _____ | Head injury _____ |
| Bladder/urinary problems _____ | Heart problems _____ |
| Bleeding problems _____ | Hepatitis _____ |
| Blood pressure problems _____ | Hypoglycemia _____ |
| Cancer _____ | Joint problems _____ |
| Colitis _____ | Kidney problems _____ |
| Colds or flu (chronic) _____ | Liver problems/Jaundice _____ |
| Diabetes _____ | Lung problems _____ |
| Digestive problems _____ | Mononucleosis _____ |
| Ear problems _____ | Osteoporosis/Osteopenia _____ |
| Eating disorder _____ | Parasites _____ |
| Edema _____ | Psychological difficulties _____ |
| Epilepsy _____ | Sexually transmitted disease _____ |
| Eye problems _____ | Sinus problems _____ |
| Fatigue (chronic) _____ | Skin problems _____ |
| Gynecological problems _____ | Stroke _____ |
| Fever _____ | Throat problems _____ |
| Gall bladder problems _____ | Thyroid problems _____ |
| Gum/Teeth problems _____ | Toxic exposure _____ |
| Gout _____ | Ulcer _____ |



Pharmaceutical medications, supplements, and diet

Please list all pharmaceutical medications (including prescription and over the counter), the dose you take, the reason you take it, and the effect you feel it is having.

Please list each supplement you are taking, the brand, the dose, the reason you are taking it, and the effect you feel it is having.

Please list the foods you know you are sensitive or allergic to (and how you found out).

Are there any foods that you crave? _____

Do you regularly consume dairy? **Y N** Wheat? **Y N** Sugar? **Y N** Veggies? **Y N**

Current energy level (low) **1 2 3 4 5 6 7 8 9 10** (high)

Current stress level (low) **1 2 3 4 5 6 7 8 9 10** (high)

Thank you for your time in filling out this form. It is valuable information to us.