Jeremy Toman, ND
(519) 889-1718
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Located inside Total Body Wellness
110 Durham St E Suite 2
Walkerton, Ontario

Adult Patient Intake – Second Visit

Name: ____________________

Personal / Psychosocial History

Height: __________ Current Weight: ___________ Weight Goal: ______________

When were you last at this goal weight? _________________

What is your average adult weight? ______________

Sexual Preference: Heterosexual ___ Bisexual ___ Homosexual ___ Other ___

Marital Status _____________________ Occupation _________________________

Do you like your work? Y / N

Average hours worked in a week ________Educational Background ____________________________

Religious or spiritual beliefs ____

Hobbies: ____

Do you have pets? Y / N If so, what kind? ____

Alcohol- how much/day or /week ________________________

Caffeine- form and amount/day __________________________

Recreational drugs- what and how often _____________________

Current Tobacco- form and amount/day _____________________Have you smoked in the past? Y / N

If so, when, how long and how much? ____

Who are the most significant others in your life and what are the challenges with each relationship?

____

____

____

Overall, how do you feel about yourself?____

____

Please indicate what immunizations you have had:

- ☐ **DPT (diphtheria, pertussis, tetanus)**
- ☐ **Haemophilus influenza B**
- ☐ **Hepatitis A**
- ☐ **Tetanus booster; when? ____________________________**
- ☐ **"Seasonal Flu"**
- ☐ **Hepatitis B**
- ☐ **MMR (measles, mumps, rubella)**
- ☐ **Polio**
- ☐ **Other_________**

Please indicate if any caused adverse reactions : ____________________________________

____

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Family History

Do you have children, if yes how many? ____

Indicate if a relative or family member has had any of the following (Indicate 'M' for mother's side and 'P' father's side):

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease / High blood pressure		Drug abuse / alcoholism	
Stroke		Kidney disease	
Cancer		Other	
Diabetes			

☐ **I don't know my family medical history**

Environment

Are you exposed to second-hand smoke on a regular basis? Y / N

Are you regularly exposed to solvents, heavy metals, fumes, pesticides/herbicides, or other toxic materials? Y / N Please describe:

____

How old is your house? ________________ How is it heated? ______________________________________

How would you describe the emotional climate of your home?

____

____

Stress

Please list your stressors and significant life events from most recent to last

Stressor/Significant Life Event	How Does This Impact You?	Degree of Impact (mild, moderate, high)

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Diet

Daily Sample Menu (include all beverages)

Meal	Time of Meal	Symptoms After Eating
Breakfast:		
Morning Snack:		
Lunch:		
Afternoon Snack:		
Dinner:		
Snack:		

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

Do you have any dietary restrictions? ____
____

List your food cravings, if any: ____

Do you enjoy preparing food (circle one)? Y / N

Physical Activity

Type of Exercise	Duration	Intensity (light, moderate, high)	Frequency/week

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Sleep

Question	Comment	Question	Comment	Question	Comment
# of Hours/night		Time to fall asleep (in mins)		Do you wake rested?	
Bed time		Times waking in night		Do you snore?	
Wake time		Favoured Sleep Position		Do you grind your teeth?	

General

Have you ever experienced anything in your life that was traumatic to you? If you are able to comment on it, please write down a few points?

____
____
____

Is there anything that you feel is important that has not been covered?

____
____
____

Thank you for taking the time to fill out this form. It helps me to understand you as an individual so that we can work together to restore and maintain your health.

Connect with Dr. Toman: Facebook: www.facebook.com/JeremyTomanND
Website: www.JeremyTomanND.com
Google +: JeremyTomanND