NATUROPATHIC PATIENT INTAKE FORM

This information is strictly confidential and is only used in accordance with our privacy policy.

CONTACT INFORMATION

Full Name: _____ Date: _____

Date of Birth: _____ Age: _____ Gender: ☐ M ☐ F ☐ O

Address: _____

City: _____ Province: _____ Postal Code: _____

Landline #: _____ Cell #: _____ Other #: _____

Personal Email: _____

Marital Status: ☐ Single ☐ Married ☐ Widowed ☐ Divorced ☐ Separated ☐ Common-Law

Number of Children: _____

Occupation: _____ Employer: _____

Emergency Contact Name: _____ Relation To You: _____

Emergency Contact #: _____

How did you hear about our clinic? _____

HEALTH CARE PROVIDER INFORMATION

Other health care providers (family physician, specialists, complementary and alternative therapy):

1. _____ 2. _____ 3. _____

Tel: _____ Tel: _____ Tel: _____

HEALTH CONCERNS

What are your main health concerns that you would like addressed?

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

MEDICAL HISTORY

How would you describe your general state of health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates. If "yes" indicate current with "C", past with "P"

	Yes	No		Yes	No		Yes	No
Anemia			Diabetes			Kidney Disease		
Arthritis			Epilepsy			Liver Disease		
Asthma			Gallbladder Disorder			Multiple Sclerosis		
Cancer			Heart Disease			Rheumatic fever		
Crohn's or Ulcerative colitis			Hepatitis			STD (please specify)		
Depression			HIV/AIDS			Thyroid disorder		

Other: _____

_____

Please list all current medications, including dosages, duration of use and why you are taking them.

Medication	**Dose**	**Duration**	**Condition Treating**

Please list all natural health products you are taking and feel free to write on the reverse side of page (vitamins, supplements, herbs, homeopathics)

Natural Health Product	Dose	Duration	Condition Treating

Please list **past** prescription medications: _____

_____

_____

How frequently are you treated with antibiotics? _____

Do you regularly use any of the following?

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills

☐ Birth control pills ☐ Implants ☐ Injections

Please list any surgeries, dates of surgery and any complications (please include all cosmetic and elective surgeries as well as dental surgery).

_____

_____

_____

_____

Do you have any allergies (medicines, environmental, etc.)?

_____

_____

_____

Alcohol—how much/ day or week: _____

Tobacco—form and amount/day: _____

Caffeine—form and amount/day : _____

Recreational drugs—what and how often: _____

Please indicate which immunizations you have had:

- ☐ DPT (diphtheria, pertussis, tetanus)
- ☐ Tetanus booster; when? _____
- ☐ MMR (measles, mumps, rubella)
- ☐ COVID (Type/Dates) _____
- ☐ Haemophilus influenza B
- ☐ "Flu"
- ☐ Polio
- ☐ Hepatitis A
- ☐ Hepatitis B
- ☐ Smallpox
- ☐ Other _____

Please indicate if any caused adverse reactions: _____

_____

_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc? ☐ Yes ☐ No

When were your most recent tests performed? _____

CURRENT CONDITIONS - Please check conditions that affect you presently.

Skin and Hair

- ☐ Rashes
- ☐ Itching
- ☐ Changing moles
- ☐ Ulcerations
- ☐ Hives
- ☐ Dandruff
- ☐ Eczema
- ☐ Pimples
- ☐ Change in hair or skin texture
- ☐ Loss of hair
- ☐ Recent moles
- ☐ Any other hair or skin problems? _____

Head, Eyes, Ears, Nose and Throat

- ☐ Dizziness
- ☐ Eye strain
- ☐ Color blindness
- ☐ Ringing in ears
- ☐ Sinus problems
- ☐ Concussions
- ☐ Eye pain
- ☐ Cataracts
- ☐ Poor hearing
- ☐ Nosebleeds
- ☐ Migraines
- ☐ Poor vision
- ☐ Blurry vision
- ☐ Spots in front of eyes
- ☐ Recurrent sore throats
- ☐ Glasses/contact
- ☐ Night Blindness
- ☐ Earaches

☐ Grinding teeth ☐ Facial pain ☐ Sores on lips or tongue
☐ Teeth problems ☐ Jaw clicks ☐ Macular degeneration
☐ Headaches (where and when)? _____
☐ Any other head or neck problems? _____

Cardiovascular

☐ High blood pressure ☐ Low blood pressure ☐ Chest pain
☐ Irregular heartbeat ☐ Dizziness ☐ Fainting
☐ Cold hands or feet ☐ Swelling of hands ☐ Swelling of feet
☐ Blood clot ☐ Phlebitis ☐ Difficulty in breathing
☐ Any other heart or blood vessel problems? _____

Respiratory

☐ Cough ☐ Coughing blood ☐ Bronchitis ☐ Pneumonia
☐ Pain with deep breath ☐ Asthma ☐ Difficulty in breathing when lying down
☐ Production of phlegm (what colour)? _____
☐ Any other lung problems? _____

Gastrointestinal

☐ Nausea ☐ Indigestion ☐ Black stools ☐ Vomiting
☐ Belching ☐ Blood in stools ☐ Constipation ☐ Gas
☐ Rectal pain ☐ Diarrhea ☐ Hemorrhoids ☐ Abdominal pain
☐ Itchy rectum ☐ Bad breath ☐ Chronic laxative use
☐ Any other problems with your stomach or intestines? _____

Genito-Urinary

☐ Pain on urination ☐ Freq. urination ☐ Blood in urine ☐ Urgency to urinate
☐ Kidney stones ☐ Decrease inflow ☐ Impotency ☐ Unable to hold urine
☐ Recurrent UTIs ☐ Sores on genitals ☐ Yeast infections
☐ Do you wake to urinate (how often)? _____
☐ Any particular colour to your urine? _____
☐ Any other problems with your genital or urinary system? _____

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Musculoskeletal

☐ Neck pain ☐ Muscle pain ☐ Knee pain ☐ Back pain
☐ Muscle weakness ☐ Foot/ ankle pain ☐ Hand/ wrist pain
☐ Shoulder pain ☐ Any other joint or bone problems? _____

Neuropsychological

☐ Seizures ☐ Dizziness ☐ Loss of balance ☐ Numbness
☐ Lack of coordination ☐ Poor memory ☐ Concussion ☐ Depression
☐ Easily susceptible to stress ☐ Quick temper ☐ Irritable ☐ Anxiety
☐ Have you ever been treated for emotional problems? ☐ Yes ☐ No
☐ Have you ever considered or attempted suicide? ☐ Yes ☐ No
☐ Any other neurological or psychological problems? _____

Pregnancy and Gynecology – Women only

Age at first menses: _____ Length of cycle: _____ Duration of menses: _____
☐ Unusual menses ☐ Painful periods ☐ Clots ☐ Heavy ☐ Light
☐ Irregular periods ☐ Last PAP: _____ ☐ Vaginal discharge
☐ Vaginal sores ☐ Breast lumps
☐ Changes in body / psyche prior to menses: _____
Do you practice birth control? ☐ Yes ☐ No
What type and for how long? _____
Could you be pregnant now? ☐ Yes ☐ No (choose Yes if it is possible)
1st day of last menses: _____
Number of pregnancies: _____
These pregnancies resulted in (please indicate the number of times):
☐ Premature birth(s): _____ ☐ Abortion(s): _____ ☐ Miscarriage(s): _____
☐ Full term birth(s): _____ ☐ Postdate birth(s): _____
Any other obstetrical or gynecological issues? _____

_____

_____

_____

DIET

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

_____

_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

_____

_____

FAMILY HISTORY

☐ I don't know my family medical history

Indicate if a close relative (parent, child, sibling) has had any of the following:

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

ENVIRONMENT

Occupation: _____

_____

Hobbies: _____

_____

Do you exercise regularly? ☐ Yes ☐ No

If yes, what do you do for exercise, for what duration and how often?

Are you exposed to significant tobacco smoke (at work, home, etc.)? ☐ Yes ☐ No

Are you frequently exposed to animals (work, pets, etc.)? ☐ Yes ☐ No

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

How would you describe the emotional climate of your home?

How would you rate your stress levels?

☐ Overwhelming ☐ High ☐ Moderate ☐ Low ☐ Minimal

OTHER CONCERNS

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

WOULD YOU LIKE TO LEARN MORE ABOUT:

- ☐ Yearly Detoxification and Cleansing Strategies
- ☐ EFT & Stress Management
- ☐ BIE & Allergy Desensitization
- ☐ Meditation
- ☐ The Bowen Technique
- ☐ Kundalini Yoga and Workshops
- ☐ Acupuncture and Cupping
- ☐ Nutrient IV or Injection Therapy

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