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Patient Intake Form

Last Name: _____ First Name: _____ Date: _____

Age: _____ Birth date: (day/month/year) ___ / ___ / ___ Personal Health Number : _____
Extended Medical: Yes/ No Does the Government subsidize your MSP premiums: Yes / No

Phone: (home) _____ (Cell) _____ (Work) _____
(Put an asterisk beside the best one to leave a message on)

Mailing Address: _____ City: _____ Postal Code: _____
Email address: _____

Occupation: _____ Employer _____

Emergency Contact: _____ Relationship: _____
Phone Number: (home) _____ (cell) _____

How did you hear about our Centre? _____

List in order of importance any health problems their duration and time of onset.

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

Are you currently under the care of any other healthcare practitioners? chiropractor acupuncturist
 massage therapist physiotherapist counselor psychiatrist medical specialist
 medical doctor: _____ other _____

FAMILY HISTORY:

Do you have any blood relatives (parent, brother/sister, aunt/uncle, grandparent) who have any of the following:
 cancer heart disease stroke high blood pressure tuberculosis
 mental illness thyroid problems osteoporosis diabetes asthma

HEALTH HISTORY:

List all surgeries, hospitalizations and injuries:

DRUG/MEDICATION HISTORY:

List all allergies and sensitivities (drugs, foods, plants, dust, animals, metals, sun, etc.):

Which of the following medications do you currently use or HAVE used in the past :

- Antidepressants Birth control Hormone Replacement Cortisone Laxatives
 Antacids Sleeping Pills NSAIDS (Tylenol, Aspirin, Motrin, Ibuprofen, etc.)

Please list your current medications and supplements and BRING ALL MEDICATIONS AND NATURAL SUPPLEMENTS WITH YOU TO YOUR FIRST APPOINTMENT:

Medications	Dose	How often?	Since when?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Supplements	Dose	How often?	Since when?
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

How often did/do you consume?

Alcohol _____	When was your last drink? _____
Antibiotics _____	For what? _____ Last dose? _____
Cigarettes/Cigars _____	If you have quit, when? _____
Recreational Drugs _____	Last time of use? _____ Coffee _____

Have you been exposed to toxic chemicals i.e. living near a golf course/orchard, handling paints, industrial chemicals or pesticides? _____

LIFE STYLE HABITS

How do you reduce or cope with stress? _____

What has given you the most stress in your life?

1. _____
2. _____
3. _____

What is your current weight? _____ lb/kg	Your weight 1 year ago _____ lb/kg
What is your ideal weight? _____ lb/kg	When were you last at that weight? _____

Do you exercise ? Yes / No	If yes, how often? _____ per week / month
Do you enjoy your work? Yes / No	Do you take vacations? Yes / No

Where have you/do you travel outside of Canada or the USA? _____

Who lives at home with you, including pets: _____

Do you have children? Yes / No If yes, how old are they: _____

What is your marital status: Married / Single Satisfying? Yes / No

Any current or past addictions (drugs, alcohol, gambling, porn, sex, internet, etc.): Yes / No

Do you have a spiritual/religious practice? Yes / No If yes, what? _____

Do you sleep well and rise refreshed in the morning? Yes / No _____

FEMALE REPRODUCTION

Age of 1st menstrual period _____ If periods have stopped, at what age? _____
 Are your cycles regular: Yes / No Period begins every _____ days.
 How long are your periods? _____ Do you have spotting between periods? Yes / No
 Are your periods: heavy ___ medium ___ light ___ Any cramps with period: Yes / No
 Vaginal discharge? Yes / No

Any *premenstrual symptoms*?

___ water retention ___ breast tenderness ___ irritability ___ depression ___ mood swings ___ food cravings
 Other _____

What kind of birth control do you currently use? _____

Have you experienced any of the following:

___ infertility ___ miscarriages ___ abnormal pap smears ___ abortion ___ breast lumps

Are you pregnant? _____ How many weeks? _____ Number of pregnancies? _____

Have you ever been sexually abused? Yes / No

MALE REPRODUCTION

Any problems with: impotency ___ prostate ___ low sperm ___ low libido ___
 Are you currently sexual active? Yes / No Have you ever been sexually abused? Yes/No

PLEASE MARK ALL THAT APPLY TO YOU: Present concerns Those you have had in the past

___ canker sores ___ burping ___ heartburn ___ bloating ___ constipation
 ___ diarrhea ___ vomiting ___ diabetes ___ bad breath ___ nausea
 ___ hernia ___ gall bladder ___ bulimia/anorexia ___ hard to swallow ___ poor appetite
 ___ anal itch ___ colitis ___ abdominal pain/cramping

Are your stools: ___ thin or pencil like ___ full of mucous ___ strong odour ___ black/tarry ___ yellow or light coloured
 ___ floating ___ loose How often do you have bowel movements? _____

___ poor concentration ___ trembling ___ joint pain ___ headache ___ hepatitis
 ___ forgetfulness ___ epilepsy ___ aching muscles ___ skin problems ___ liver disease
 ___ panic attacks ___ sleep difficulties ___ eye problems ___ anxiety/worry ___ easy bruising
 ___ numbness/ tingling ___ mental illness ___ tendency to irritability ___ tendency to depression

___ asthma ___ stuffy sinus ___ chronic bronchitis ___ pneumonia ___ runny nose
 ___ cough with mucous ___ shortness of breath ___ hay fever/allergies ___ frequent colds/infections

___ ringing in ears ___ dizziness ___ disinterest in sex ___ feel jittery ___ gout
 ___ frequent urination ___ burning urination ___ urinate at night ___ cold hands/feet ___ swollen feet
 ___ fatigue ___ urgency to urinate ___ kidney disease ___ night sweats ___ kidney stones

___ heart palpitations ___ high cholesterol ___ high blood pressure ___ heart murmur ___ heart attack
 ___ pain in chest ___ angina ___ anemia ___ stroke ___ hemorrhoids

___ thyroid disease ___ cancer ___ mononucleosis ___ ear infections ___ tonsillitis
 ___ herpes/shingles ___ abscess ___ sore throat ___ venereal disease ___ boils

Does your temperature tend to run high /low /average compared to others?

Any thing else? _____

Thank you for taking the time to complete this form. We look forward to working with you.

We are located at 103B-1980 Cooper Road in Orchard Plaza II facing Zellers. Look for us under the blue awning marked Naturopathic Clinic. Please call if you need further directions: **250-762-5100**.