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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 X:
__ 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 **X**

__ 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**.