



Naturopathic Intake Form

Personal Information

Date: _____

Name: _____ Age: _____

Birth Date (dd/mm/yyyy): _____ Sex: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone: (Home) _____ (Cell) _____

Email (please use all CAPS letters):

If under 18, caregiver's name(s): _____

Occupation: _____

Marital Status (if applicable): _____

Number of Children (if applicable): _____

Family Physician: _____

Phone Number: _____ Fax Number: _____

In Case of emergency contact: _____

Address: _____ Phone Number: _____

Relationship: _____

How did you hear about our clinic? _____

Have you seen a Naturopathic Doctor before? Yes No

If yes, for what reason(s)? _____

I would like to be on the clinic's general mailing list to receive clinic information, such as subscriber specials and the clinic newsletter. Please circle YES/NO.

Current Health History

Height: _____ Weight: _____ Weight one year ago: _____

Are you concerned about your weight? Yes No

Please rank your main concerns in order of importance to you and when they started:

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

Please list any current diagnoses you have been given (if any) and when:

What activities aggravate your condition? _____

Does your health concern interfere with any of the following?

Work Sleep Daily Routine Other

Please list any allergies you have:

Have you ever had any mental or emotional disorders? _____

If yes, please list: _____

If yes, when? _____

When was your last physical exam? _____

When did you last have blood work done? _____

Please indicate how often you go for dental visits:

Every 6 Months Yearly Toothache or Emergency Wear Dentures

What other therapies are you currently using? (Chiropractic, Physiotherapy, Acupuncture etc)

What other treatments have you tried in the past for these concerns?

Are you currently under the care of any other physicians or practitioners? Yes No

If yes, please give names and contact info:

Medication and Supplement History

Please list all supplements, herbs, and medications you are currently taking:

Medication (Please list all of your prescription and non-prescription medication, including birth control, aspirin, and over the counter medications)

Medication	Dosage	Since	Reason

Are you currently experiencing any side effects from your medication? Yes No

Supplements (Please list any vitamin, mineral, or natural supplements you are taking with doses and brands)

Supplements	Dosage	Since	Reason

History of antibiotic use: (last two years)

When: _____

How long: _____

For what condition(s):

Did you experience any side effects? Yes No

Health History

Please indicate which of the following conditions you have had:

Abscesses	Goiter	Pneumonia
Alcoholism/Substance abuse	Gout	Prostatitis
Allergies/Hay fever	Heart Disease	Rheum. Fever
Amnesia	Hepatitis	Rubella
Anemia	High Blood Pressure	Scarlet Fever
Anxiety/Depression	Influenza	Sexually Transmitted Infection
Asthma	Kidney Disease	Sinusitis
Autoimmune disease	Leukemia	Skin Disease
Bells' Palsy	Lyme disease	Sleep apnea
Cancer	Malaria	Strep Throat
Chicken Pox	Measles	Stroke
Cold Sores	Miscarriage	Thyroid disease
Concussion	Mononucleosis	Tonsillitis
Diabetes	Mumps	Tuberculosis
Eating Disorder	Neurological disease	Typhoid
Emphysema	Obesity	Warts
Epilepsy	Osteoporosis	Yellow Fever
Eye disease	Parasites	
Gall Stones	Peritonitis	

Please indicate if you have or have had any of the following symptoms (C for currently experiencing and P for experienced in the past):

GENERAL

- Allergies
- Chills
- Convulsions
- Dizziness
- Fainting
- Fatigue
- Headache
- Migraines
- Loss of sleep
- Weight loss
- Weight gain
- Nervousness
- Depression
- Neuralgia
- Sweats
- Tremors
- Weakness

GASTROINTESTINAL

- Abdominal pain

- Acid reflux
- Belching
- Bloating
- Blood in mucous or stool
- Change in taste or thirst
- Colitis/IBD
- Constipation
- Diarrhea/loose stools
- Difficult digestion
- Excessive hunger
- Gallbladder trouble
- Heartburn
- Hemorrhoids
- Jaundice
- Liver trouble
- Nausea
- Poor appetite
- Rectal itching
- Trouble swallowing
- Ulcers

- Vomiting
- Vomiting of blood

How often do you have a bowel movement?

Have you had a colonoscopy? Yes/No
If yes, when? _____

CARDIOVASCULAR

- Arteriosclerosis or Atherosclerosis
- Chest pain
- Clots
- Deep leg pain
- High blood pressure
- High cholesterol
- Low blood pressure
- Murmur
- Pitting edema

- Poor circulation
- Rapid heart beat/palpitations
- Swelling of ankles
- Varicose veins

RESPIRATORY

- Chronic cough
- Difficult breathing
- Pain with breathing
- Shortness of breath while laying down
- Shortness of breath with activity
- Slow breathing
- Spitting up blood
- Spitting up phlegm
- Wheezing

MUSCOSKELETAL

- Bursitis
- Difficulty chewing/jaw clicking
- Hernia
- Joint pain
- Joint stiffness
- Joint swelling/redness
- Low back pain
- Muscle spasms/cramps
- Neck pain/stiffness
- Numbness/tingling
- Osteoarthritis
- Rheumatoid arthritis
- Shoulder pain
- Tendonitis

NEUROLOGICAL

- Bells' palsy
- Carpal tunnel syndrome
- Paralysis
- Peripheral neuropathy
- Sciatica
- Tremors

EYES, EARS, NOSE, THROAT

- Bad breath
- Blurry vision
- Deafness
- Dental decay
- Detached retina
- Double vision
- Ear discharge
- Earache
- Enlarged glands/Swollen lymph
- Enlarged thyroid
- Eye pain
- Eye strain
- Far-sightedness
- Floaters
- Gingivitis
- Glaucoma
- Gum trouble
- Hay fever
- Hoarseness
- Increased ocular pressure
- Loss of central vision
- Loss of peripheral vision
- Loss of taste or smell
- Macular edema
- Mercury fillings
- Mouth sores
- Nasal obstruction
- Near-sightedness
- Nosebleeds
- Root canals
- Sensitivity to light
- Sensitivity to noise
- Sinus infection
- Sore throat
- Tearing or dryness
- Tinnitus
- Tonsillitis
- Tooth pain

SKIN

- Acne

- Bruise easily
- Cellulite
- Dryness/Eczema
- Hair loss
- Hives/Allergies
- Itching
- Moles removed
- Psoriasis
- Rash
- Rosacea
- Vitiligo

GENITO-URINARY

- Bed-wetting
- Blood in urine
- Frequent urination
- Painful urination

MEN

- Erectile dysfunction
- Low libido
- Penile discharge
- Prostatitis

Have you had a rectal exam? Yes/No
If yes, when? _____

WOMEN

- Excessive menstrual flow
- Fertility issues
- Low libido
- Lumps in breast
- Menopausal symptoms
- Painful menstruation
- Tender/swollen breasts
- Vaginal discharge

Are you pregnant? ____
Number of pregnancies: ____

Have you had a recent pap? ____
Have you had a recent mammogram? ____



Please indicate if you've had any hospitalizations, surgeries, or serious injuries:

Hospitalizations/Surgeries:

Operation	When	Complications?

Injuries:

Injury	When	Long-Term Effects?

Diet and Lifestyle

How much of the following substances do you use on a daily basis? (Heavy, moderate light, or none)

Alcohol: _____ Caffeine: _____
 Recreational Drugs: _____ Laxatives: _____ Carbonated beverages: _____

Are you seeking guidance in nutrition and daily lifestyle? Yes No

Do you use any tobacco products? _____ Type and quantity per day: _____

Have you had a recent chest x-ray? _____ If yes, when? _____

Have you had any exposure to toxic chemicals? _____ If yes, which ones:

Are there any foods or food groups that you avoid? Yes No
 If yes, which ones and why?

How often do you engage in physical activity?
 Daily ____ 2-3 times/week ____ Once/week ____ Less than once/week ____
 What type of activities? _____

On average, how many hours of sleep do you get per night? _____

How many glasses of water do you drink per day? _____



Have you traveled to a foreign country in the last five years? ____ If yes, where? _____

Please list any illnesses you had while abroad: _____

Have you had any recent vaccinations? ____ If yes, which ones: _____



Family Health History

Please indicate any relevant health conditions of your blood relatives only.

Relation	Past and Present Health Problems	Age at time of death (if applicable)

INFORMED CONSENT

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) _____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I understand that, as a patient, I am responsible for all costs incurred as a result of this decision including, but not limited to; the cost of all procedures involved in the treatment plan, the care provider's time, supplements, supplies and appointments missed or cancelled without sufficient notice (48 hours). I am aware that treatments are not covered through Alberta Health Care and may not be covered under private health insurance.

SIGNATURE

DATE

Witness