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NEW PATIENT INTAKE FORM

**Please bring copies of all recent blood work and test results to your first appointment*
**Please bring all prescription medications OR a print out from the pharmacist with all your prescription medications to your first appointment*
**Please bring all supplements and other remedies with you to your first appointment*

Today's Date: ____________________
Name:____________________________Age:_______ Date of Birth:_______________Gender:______
MSP (Care Card) Number _________________________________
Mailing Address:_______________________________City:_____________Postal Code:___________
Location Address (if different):____________________________________City:_________________
Home phone: ___________________________(can we leave a message at this number?) ________
Email: _______________________________(can we add you to our newsletter list?) ___________
Work phone:______________________ Cell phone: ______________________
Emergency Contact (include name, number, and relationship to you): _________________________
____
How did you hear about this clinic?____
Has any other family member been a patient at this clinic?___________________________________
Who is your family doctor (MD?)____
Are you currently under the care of any medical specialists? If so, please list below.
____
____
____
____

Are you currently seeing any other health care provider? e.g.) another naturopathic physician, chiropractor, acupuncturist, massage therapist, counselor, etc. If so, please list below.
____
____
____
____

When, where and from who did you last receive medical or health care? _______________________
____

HEALTH CONCERNS
What are your most important health concerns? List all that you have, in order of importance.
____
____
____
____
____

Has anything recently changed, or become worse? _______________________________________
____

CONTEXT OF CARE

Why did you choose to come to our clinic? ____
____

What do you know about our approach to health care? _________________________________
____

If 100% is perfect health, how would you rate your overall, current state of health? ___________

What expectations do you have from *this visit* to our clinic? ___________________________
____
____

What are the *long term* expectations you have from us? _______________________________
____
____

What are your expectations from me, personally, as your physician? _____________________
____
____

What is your present level of commitment toward addressing the underlying causes of your signs and symptoms that may be related to lifestyle? Rate from zero to 100% commitment:

0% 10 20 30 40 50 60 70 80 90 100%

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? ____
____
____

What behaviours or lifestyle habits do you currently engage in regularly that you believe are harming your health? ____
____
____

What potential problems or obstacles may you have in making changes to your current behaviours or lifestyle habits or in sticking to your treatment plan? _____________________________
____
____

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making? ____

What do you love to do? ____

HEALTH HISTORY

General Information

Is there any chance you are currently pregnant? ______________________________

Do you have a contagious disease at this time? ______________________________

Do you have any chronic health condition which you did not list under the "Health Concerns" section?

____

Have you ever been diagnosed with cancer?______________________________

Weight:_____lbs Weight 1 year ago:_______ lbs Maximum weight:_________lbs When:______

What do you think your ideal weight is? _______ lbs When was the last time you weighed this? ______

Height:___________ If you are over age 20, is your height the same as it was at age 20? ______

Blood type, if known:___________ Have you ever received a blood transfusion? _____________

Current Medications and Supplements

**Please bring all medications and supplements to your first appointment*

Please list any prescription medications, over-the-counter medications, vitamins or other supplements you are taking. Please include dosages. Remember to include: appetite suppressants, antacids, laxatives, pain relievers, cortisone/prednisone, nasal decongestants tranquilizers, anti-depressants, sleeping pills, hormones, birth control pills and anything else you take regularly or are on currently. (List on a separate sheet if you take more medications or supplements than can be listed below.)

____

____

____

____

____

____

Childhood (Note: If unknown, just leave blank)

If known, how was your mother's health and well being during her pregnancy with you?

____

Were you born prematurely? _____ Vaginal or C-section birth? ____Weight at birth, if known. _______

Were there any unusual or traumatic events related to your birth? ______________________________

____

Were you breast fed? __________ For how long? __________Did you have colic as a baby? ________

Were there any significant illnesses, accidents or traumatic events during your infancy? ____________

____

Were there any significant illnesses, accidents or traumatic events during your preschool years? _____

____

Were there any significant illnesses, accidents or traumatic events up to puberty? ________________

____

Vaccinations

Did you receive the standard vaccinations available during your childhood? ________________

Have you ever received vaccinations for any of the following as an adult? (please check)

Measles, Mumps, Rubella	Haemophilus	Meningitis	Chicken pox
Pertussis (whooping cough)	Diphtheria, Tetanus	Polio	Small pox
Hepatitis B	HPV	Pneumonia (year of last one)__________	

Influenza (how often, year of last one) ______________________________

Other vaccinations for travel – please list: ______________________________

What was the date of your last tetanus shot? ______________________________

Have you ever had an unusual reaction to a vaccination? ______________________________

____

Contagious Diseases – Have you ever had any of the following?

Rubella	Measles	Mumps	Chickenpox
Whooping Cough	Rheumatic Fever	Polio	Scarlet Fever
Mononucleosis	Meningitis	Malaria	Hepatitis A or B
Pneumonia	Tuberculosis	Other ___________________________	

Health History

Have you ever been diagnosed with any of the following? If so, please give details below.

Cancer	HIV	Liver disease	Hepatitis C
Heart attack	Stroke or TIA	Other heart disease	High blood pressure
Diabetes	Kidney disease	Neurological disease	Concussion or head injury
Asthma	Emphysema or COPD		

Other serious illness:

____
____
____
____
____

Hospitalizations and Surgeries

Have you ever been in the hospital? If so, please describe below.
Have you ever had surgery? If so, please describe below.
Have you ever had a serious accident? If so, please describe below.

____
____
____
____

Diagnostic Tests

Have you ever had any of the following diagnostic tests? Is so, please list when & why, and what the results were. **If you have recent results, please bring them to your first appointment.*

Electrocardiogram (EKG)	Angiogram or other Heart Tests	Ultrasound
Electroencephalogram (EEG)	X-rays, CAT scans, MRI	Other

____
____
____
____

Allergies

Are you hypersensitive or allergic to:
Any Drugs?____
Any Foods?____
Do you avoid these Foods? ____
Any Chemicals?____
Any Environmental Toxins?____
What happens to you when you have an 'allergy attack?'____________________________
____
What types of allergy testing have you had?____
____

Social History

Relationship status: e.g.) Married, Separated, Divorced, Widowed, Single, Partnership ____________
Who do you normally live with: e.g.) spouse/partner, children, parents, friends, pets _______________
____

Occupation:____Location:__________________________
If retired, previous occupation ____
Do you enjoy your work (or your retirement)? ____
How many hours per week do you work? __________ Do you commute? ______ How long? _______
Have you ever had a job that you felt exposed you to dangerous or toxic compounds? _____________
If so, please explain____

Habits

Do you (or did you) smoke? If so, what do you smoke? How much? And, for how many years?_____
____
Are you regularly exposed to second hand smoke? ____________________________________
Do you use any recreational drugs currently, or in the past? ___________________________
____
Do you drink alcohol? _________ What type? _________________How many days/week? ________
How many drinks/day during the week? ___________ On the weekends? ______________________
Have you ever had a problem with alcohol? _________Have you ever attended AA or Alanon?_______
How many cups do you have of the following, on average, each day?
coffee ______ tea ________ pop _______water ______ juice ______ other _______________________

Do you exercise regularly? If so, what do you do? How often? And for how long each time?
____
____
If you don't exercise regularly, why not? ____
____

How is your sleep? ____
How often do you wake up or get up during the night? Why? ___________________________
What time do you go to bed? _________ What time do you usually get up? ____________________
Do you need an alarm to wake up? __________ Do you feel rested in the morning? ______________
Do you need coffee or other stimulants to get going in the morning? ________________________

On a scale of 1 to 10, where 10 is the highest, please rate your average STRESS level ____________

On a scale of 1 to 10, where 10 is the highest, please rate your average ENERGY level ___________

Diet

How many times/day do you usually eat? Meals_____________ Snacks ________________
How many days/week do you eat breakfast? ______________Do you usually eat after dinner? ______
Do you restrict your diet in any way? ____
Do you crave any type of food? If so, what? ____
How often do you go on a diet? ____
Do you have, or have you ever had an eating disorder? ______________________________
Do you have any digestive problems? ____
How often do you have a bowel movement? ______________________Is this a change?____________
Do you have a tendency to develop constipation? ________________ Diarrhea? _________________

Typical Food Intake – please list the foods you typically eat for each of the following:

Breakfast:____
____

Lunch:____
____

Dinner:____
____

Snacks:____
____

Drinks:____
____

FAMILY MEDICAL HISTORY

	Father	Mother	Brothers	Sisters	Children
Age (if living)	______	______	____________	____________	____________
Overall Health	______	______	____________	____________	____________
Age at death	______	______	____________	____________	____________
Cause of death	______	______	____________	____________	____________

Check those applicable:

	Father	Mother	Brothers	Sisters	Children
Heart Disease	______	______	____________	____________	____________
High Blood Pressure	______	______	____________	____________	____________
Diabetes	______	______	____________	____________	____________
Cancer	______	______	____________	____________	____________
Asthma	______	______	____________	____________	____________
Hay fever/Hives	______	______	____________	____________	____________
Arthritis	______	______	____________	____________	____________
Glaucoma	______	______	____________	____________	____________
Thyroid problems	______	______	____________	____________	____________
Anemia	______	______	____________	____________	____________
Kidney Disease	______	______	____________	____________	____________
Mental Illness	______	______	____________	____________	____________
Seizures/Epilepsy	______	______	____________	____________	____________
Stroke	______	______	____________	____________	____________
Tuberculosis	______	______	____________	____________	____________
Other_______	______	______	____________	____________	____________
Other_______	______	______	____________	____________	____________

REVIEW OF SYSTEMS

Please indicate if you currently have, of have had in the past, any of the following:

Yes – a condition you now have Past - a condition you have had before

Head	Yes	Past
Headaches	_	_
Migraines	_	_
Fainting	_	_
Head injury/Concussion	_	_
Jaw/TMJ problems	_	_

Eyes		
Glasses or contacts	_	_
Blurred vision	_	_
Impaired vision	_	_
Double vision	_	_
Eye pain/strain	_	_
Colour blindness	_	_
Light sensitivity	_	_
Spots in eyes	_	_
Tearing	_	_
Dryness	_	_
Cataracts	_	_
Glaucoma	_	_
Macular degeneration	_	_
Diabetic Retinopathy	_	_

Nose and Sinuses	_	_
Frequent colds	_	_
Sinus problems	_	_
Chronic Stuffiness	_	_
Nosebleeds	_	_
Hay fever	_	_
Loss of smell	_	_

Cardiovascular system		
Heart Disease	_	_
Angina/chest pain	_	_
Palpitations	_	_
Racing/abnormal heart beat	_	_
Heart murmur	_	_
Rheumatic fever	_	_
High blood pressure	_	_
Low blood pressure	_	_
Atherosclerosis	_	_
Blood clots	_	_
Phlebitis	_	_
Swelling in ankles		

Ears	Yes	Past
Earaches	_	_
Ringing in ears	_	_
Dizziness	_	_
Discharge from ears	_	_
Hearing problems	_	_
Sensitivity to noise	_	_

Neck		
Lumps	_	_
Swollen Glands	_	_
Goiter	_	_
Pain or stiffness	_	_
Whiplash	_	_

Mouth and Throat		
Cold sores	_	_
Canker sores	_	_
Mouth ulcers	_	_
Bleeding gums	_	_
Many cavities	_	_
Mercury fillings	_	_
Teeth grinding	_	_
Dentures/ implants	_	_
Bad breath	_	_
Off taste in mouth	_	_
Burning/painful tongue	_	_
Speech difficulties	_	_
Loss of voice	_	_
Frequent sore throat	_	_
Hoarseness	_	_

Lungs		
Cough	_	_
Sputum production	_	_
Coughing up blood	_	_
Wheezing	_	_
Asthma	_	_
Shortness of breath	_	_
Difficulty breathing	_	_
Pain with breathing	_	_
Bronchitis	_	_
Pneumonia	_	_
Emphysema/COPD	_	_
Tuberculosis	_	_
Do you smoke?	_	_

Digestion	Yes	Past
Increased appetite	_	_
Decreased appetite	_	_
Increased thirst	_	_
Difficulty swallowing	_	_
Heartburn	_	_
Frequent/chronic nausea	_	_
Frequent vomiting	_	_
Vomiting blood	_	_
Eating disorder	_	_
Frequent belching	_	_
Frequent upset stomach	_	_
Stomach ulcers	_	_
Frequent use of antacids	_	_
Frequent or excess gas	_	_
Frequent bloating	_	_
Abdominal pain/cramps	_	_
Abdominal hernia	_	_
Diarrhea	_	_
Constipation	_	_
Blood in stool/black stool	_	_
Painful bowel movement	_	_
Hemorrhoids	_	_
Anal fissure	_	_

Muscles and Joints	_	_
Joint pain or stiffness	_	_
Arthritis	_	_
Broken bones	_	_
Muscle spasms or cramps	_	_
Back pain	_	_
Muscle weakness	_	_
	_	_

Hormone Systems	_	_
Hypothyroid		
Hyperthyroid		
Heat/cold intolerance	_	_
Hypoglycemia	_	_
Diabetes	_	_
Excessive hunger	_	_
Excessive thirst	_	_
Pronounced or easy fatigue	_	_
Seasonal depression	_	_
Unexplained weight loss/gain	_	_

Liver	Yes	Past
Jaundice	_	_
Fatty liver	_	_
Hepatitis	_	_
Other liver disease	_	_

Gallbladder	_	_
Gallstones	_	_
Gallbladder pain	_	_
Gallbladder removed	_	_

Kidney and Bladder	_	_
Pain with urination	_	_
Frequent urination	_	_
Frequency at night	_	_
Inability to hold urine	_	_
Problems starting urine	_	_
Many urinary infections	_	_
Blood in urine	_	_
Kidney stones	_	_

Body Odour	_	_
Strong body odour	_	_

Skin and Hair	_	_
Acne/boils	_	_
Rashes/Hives	_	_
Eczema/psoriasis	_	_
Itching without rash	_	_
Colour changes	_	_
Lumps	_	_
Warts	_	_
Thinning or losing hair	_	_
Change in hair texture	_	_
Dandruff	_	_

Blood and Circulation	_	_
Easy bleeding/bruising	_	_
Bleeding from unusual places	_	_
Varicose veins	_	_
Thrombophlebitis	_	_
Foot/ankle ulcers	_	_
Cold hands or feet	_	_
Anemia	_	_
Deep leg pain	_	_
Swollen ankles	_	_
Fluid retention	_	_

Immune System	Yes	Past
Frequent colds/flu	_	_
Chronic/frequent infections	_	_
Chronically swollen glands	_	_
Slow wound healing	_	_
History of cancer	_	_

Male Reproduction	Yes	Past
Erectile dysfunction (ED)	_	_
Discharge from penis	_	_
Sores or lesions	_	_
Testicular mass	_	_
Testicular pain	_	_
Painful erections	_	_
Prostate disease	_	_
Vasectomy	_	_

Men and Women	Yes	Past
Syphilis	_	_
Chlamydia/Gonorrhea	_	_
Genital herpes	_	_
Condyloma/genital warts	_	_
Fertility problems	_	_
Decreased sexual desire	_	_

Female Reproduction	Yes	Past
Age of first menses	________________	
Date of last menstrual period	________________	
Length of menstrual cycle	________________	
Duration of each menses	________________	
Irregular cycles	_	_
Heavy menstrual bleeding	_	_
Bleeding between periods	_	_
Blood clots with periods	_	_
Painful cramps with menses	_	_
Endometriosis	_	_
Ovarian cysts	_	_
Fibroids	_	_
Pelvic pain	_	_
Pain with intercourse	_	_
Abnormal vaginal discharge	_	_
Date of last PAP test	________________	
Abnormal PAP test	_	_
Number of pregnancies	________________	
Number of live births	________________	
Do you do breast exams?	_	_
Breast pain/tenderness	_	_
Breast lumps	_	_
Nipple discharge	_	_

Women

Do you have PMS? If so, please explain ____

____

Do you have menopausal symptoms? If so, please explain __________________________________

____

Mental Health	Yes	Past
Received counseling	_	_
Irritability	_	_
Mood swings	_	_
Depression	_	_
Considered/attempted suicide	_	_
Panic attacks	_	_
Anxiety/Nervousness	_	_
Worry	_	_
Tension and stress	_	_

Neurological System	Yes	Past
Seizures/epilepsy	_	_
Involuntary movements	_	_
Paralysis	_	_
Weakness	_	_
Difficulty moving arms/legs	_	_
Numbness or tingling	_	_
Unexplained pain	_	_
Loss of memory	_	_
Difficulty concentrating	_	_
Difficulty thinking/focusing	_	_
Loss of balance/vertigo	_	_
Behavior/personality changes	_	_

Thank you! We appreciate the time it took you to fill out this form. The information you provided will be very helpful for us, and important in providing you with the best possible care. Please let us know if you have any questions, comments or concerns about this form.