Centre for NATURAL MEDICINE
Naturopathic Health and Wellness Clinic

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Intake Form (Age 13 and up)

Date: _____ ❑ Female ❑ Male

Patient's Legal Name:

_____
FIRST MIDDLE INITIAL LAST

Age : _____ Date of Birth: _____/_____/_____
MONTH DAY YEAR

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone : ( ) _____ (Home)

( ) _____ (Work)

( ) _____ (Cell)

MHSC (6 digit): _____ PHIN (9 digit): _____

Name of Parent/Guardian if patient is under 18 years old:

_____

Email: _____

Your email address will only be used for correspondence from the Centre For Natural Medicine.

Occupation: _____

Hours per week: _____ or ❑ Student ❑ Retired ❑ Unemployed

Hobbies: _____

_____

How did you hear about this clinic? _____

_____

What are your expectations from this visit/treatment? _____

_____

_____

Due to the chemical sensitivity of some of our patients, we ask that you please refrain from wearing perfume or cologne when visiting the clinic.

***

CANCELLATION POLICY: *Scheduled appointments are reserved especially for you. A missed appointment takes time away from serving our other patients health care needs. Patients with same day cancellations or no-shows will be charged half of their original appointment fee for their unkept appointment. Whenever possible we ask for 48 hours notice for cancellations or rescheduling.* ***Thank you for your cooperation.***

***

Payment is made at the time of your appointment. A receipt will be provided.

Please complete the following questions

What are your most important health problems that you are seeking treatment for or are currently being treated for? List as many as you can in order of importance.

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

ALLERGIES

Are you hypersensitive or allergic to any of the following (please list):

Drugs? _____

Foods? _____

Environmentals? (pollen, dust, etc.) _____

_____

CURRENT MEDICATIONS

Please list **any** prescription medications, over the counter medications, vitamins or other supplements you're taking and reason/condition for using them:

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

TYPICAL FOOD INTAKE

Breakfast: _____

_____

Lunch: _____

_____

Dinner: _____

_____

TYPICAL FOOD INTAKE (continued)

Snacks: _____

_____

Beverages: _____

Frequently Eaten Foods: _____

_____

GENERAL

Weight: _____ lbs Height: _____ ft. _____ in.

Weight 1 year ago: _____ lbs

Max. Weight / When: _____

Do you exercise?	❑ Yes	❑ No
Have a supportive relationship?	❑ Yes	❑ No
Had any major traumas?	❑ Yes	❑ No
Have a history of abuse?	❑ Yes	❑ No
Treated for drug dependence?	❑ Yes	❑ No
Treated for alcoholism?	❑ Yes	❑ No
Do you smoke tobacco?	❑ Yes	❑ No
Do you use recreational drugs?	❑ Yes	❑ No

WOMEN'S HEALTH

Are you pregnant?	❑ Yes	❑ No
Have you had a hysterectomy?	❑ Yes	❑ No
Is your menstrual cycle regular?	❑ Yes	❑ No
Do you suffer from any pre-menstrual symptoms?	❑ Yes	❑ No

If Yes, which ones? _____

_____

When was your last menstrual cycle?

_____

During your cycle, is bleeding

❑ Normal ❑ Slow ❑ Heavy

Review of Systems

Please check the appropriate answer:

Yes = Yes, a condition you are experiencing ***now***
No = No, a condition you have ***never*** had
Past = A condition you ***have had*** in the past

MENTAL/EMOTIONAL

Mood Swings	❑ Yes	❑ No	❑ Past
Anxiety or nervousness	❑ Yes	❑ No	❑ Past
Poor Concentration	❑ Yes	❑ No	❑ Past
Memory Problems	❑ Yes	❑ No	❑ Past

ENDOCRINE

Low thyroid	❑ Yes	❑ No	❑ Past
Heat or cold intolerance	❑ Yes	❑ No	❑ Past
Low blood sugar	❑ Yes	❑ No	❑ Past
Diabetes	❑ Yes	❑ No	❑ Past
Fatigue	❑ Yes	❑ No	❑ Past
Seasonal Depression	❑ Yes	❑ No	❑ Past

IMMUNE

Vaccinations	❑ Yes	❑ No	❑ Past
Reactions to vaccinations	❑ Yes	❑ No	❑ Past
Chronic infections	❑ Yes	❑ No	❑ Past
Chronic swollen glands	❑ Yes	❑ No	❑ Past
Slow Wound Healing	❑ Yes	❑ No	❑ Past

SKIN

Rashes	❑ Yes	❑ No	❑ Past
Eczema, Hives	❑ Yes	❑ No	❑ Past
Acne, Boils	❑ Yes	❑ No	❑ Past
Itching	❑ Yes	❑ No	❑ Past

HEAD

Headaches	❑ Yes	❑ No	❑ Past
Migraines	❑ Yes	❑ No	❑ Past
Head Injury	❑ Yes	❑ No	❑ Past

EARS

Earaches	❑ Yes	❑ No	❑ Past
Impaired Hearing	❑ Yes	❑ No	❑ Past
Dizziness	❑ Yes	❑ No	❑ Past
Ringing in Ears	❑ Yes	❑ No	❑ Past

NOSE AND SINUSES

Frequent colds	❑ Yes	❑ No	❑ Past
Nosebleeds	❑ Yes	❑ No	❑ Past
Stuffiness	❑ Yes	❑ No	❑ Past
Hay fever	❑ Yes	❑ No	❑ Past
Sinus Problems	❑ Yes	❑ No	❑ Past
Loss of Smell	❑ Yes	❑ No	❑ Past

MOUTH AND THROAT

Frequent sore throat	❑ Yes	❑ No	❑ Past
Sore tongue/lips	❑ Yes	❑ No	❑ Past
Gingivitis (gum disease)	❑ Yes	❑ No	❑ Past

RESPIRATORY

Cough	❑ Yes	❑ No	❑ Past
Wheezing	❑ Yes	❑ No	❑ Past
Asthma	❑ Yes	❑ No	❑ Past
Bronchitis	❑ Yes	❑ No	❑ Past

CARDIOVASCULAR

Heart Disease	❑ Yes	❑ No	❑ Past
High/Low Blood Pressure	❑ Yes	❑ No	❑ Past
Palpitations	❑ Yes	❑ No	❑ Past

GASTROINTESTINAL

Heartburn	❑ Yes	❑ No	❑ Past
Belching or passing gas	❑ Yes	❑ No	❑ Past
Change in thirst	❑ Yes	❑ No	❑ Past
Change in appetite	❑ Yes	❑ No	❑ Past
Constipation	❑ Yes	❑ No	❑ Past
Diarrhea	❑ Yes	❑ No	❑ Past

How many bowel movements a day? _____

Is this a change? ❑ Yes ❑ No

URINARY

Increased frequency	❑ Yes	❑ No	❑ Past
Frequency at night	❑ Yes	❑ No	❑ Past
Frequent Infections	❑ Yes	❑ No	❑ Past

MUSCULOSKELETAL

Joint pain	❑ Yes	❑ No	❑ Past
Stiffness in joints	❑ Yes	❑ No	❑ Past
Muscle spasms	❑ Yes	❑ No	❑ Past
Arthritis	❑ Yes	❑ No	❑ Past
Cramps	❑ Yes	❑ No	❑ Past

SLEEP

Hours per night _____

Trouble falling asleep	❑ Yes	❑ No	❑ Past
Interrupted sleep	❑ Yes	❑ No	❑ Past

If yes, please explain _____

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, cost of laboratory tests, administrative fees, missed appointment fees as well as other applicable fees. A receipt will be provided for your private insurance coverage and/or income tax purposes.

PATIENT'S FULL NAME: _____ **DATE OF CONSENT:** _____

FIRST MIDDLE LAST dd / mm / yy

_____ SIGNATURE OF PATIENT (OR PARENT OR LEGAL GUARDIAN)