



**Centre for
NATURAL MEDICINE**

Naturopathic Health and Wellness Clinic

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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.

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? _____

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
Stiffness 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)