Centre for NATURAL MEDICINE
Naturopathic Health and Wellness Clinic

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We are a scent free clinic. Thank you for your cooperation.

CANCELLATION POLICY

Scheduled appointments are reserved especially for you. We require **2 full business days'** notice for cancellations or rescheduling. We do not accept appointment changes via email

Please call 204-488-6528 for your scheduling needs. Same day cancellations or no-shows will be charged half of their original appointment fee for their missed appointment.

Thank you for your cooperation.

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

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Intake Form (Age 13 and up)

Date: _____

Patient's Legal Name:

_____
First Middle Last

Age: _____ Date of Birth: ____/____/____ Gender: _____
M D Y

Preferred Pronouns: _____

Address: _____

City: _____

Province: _____ Postal Code: _____

Telephone: (____) _____ Home
(____) _____ Work
(____) _____ Cell

Emergency contact: Name: _____

Phone: _____ Relationship: _____

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

Name of parent/guardian if patient is under 18 years of age:

_____
First Middle Last

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 the 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? _____

Environmental (dust, pollen, etc.)? _____

_____

CURRENT MEDICATIONS

Please list any prescription medications, over the counter medications, vitamins, or other supplements you are taking, and the 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: _____ (lbs) When? _____

Do/have you:

Exercise? ☐ Yes ☐ No

Have a supportive relationship? ☐ Yes ☐ No

Had any major traumas? ☐ Yes ☐ No

Had a history of abuse? ☐ Yes ☐ No

Been treated for drug dependence? ☐ Yes ☐ No

Been treated for alcoholism? ☐ Yes ☐ No

Smoke tobacco? ☐ Yes ☐ No

Use recreational drugs? ☐ Yes ☐ No

GYNECOLOGICAL 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 Symptoms

(Please check the appropriate answer)

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	☐ Yes	☐ No	☐ Past
Hives	☐ Yes	☐ No	☐ Past
Acne	☐ 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/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/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 per day? _____

Is this a change? _____

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, (PRINT) agree to pay the full amount for myself or _____(patient name if under 18) for all services rendered each time for telephone/telemedicine appointment, in-office visit or treatment, fees for services, supplements and remedies, laboratory tests, administrative fees, as well as other applicable fees and applicable taxes.

I AGREE to call your office at 204-488-6528 for any appointment changes (CFNM does not accept changes via email). I understand you require 2 full business day notice for any appointment change or a fee will be charged.

Parent/Guardian: By signing below, I am confirming that I have medical decision-making responsibility for this minor.

_____ _____

SIGNATURE OF PATIENT (OR PARENT/LEGAL GUARDIAN) DATE OF CONSENT