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Naturopathic Medical Clinic

Confidential Patient Intake Form

Date: _____

Full Name: _____ Gender: Male__ Female __

Name you prefer to be called: _____

Birthdate (dd/mm/yyyy): ____/____/____ Current age: _____

Home phone: _____

Phone number best to contact you: _____ Home__ Cell __ Work __

Home address: _____

Mailing address (if different): _____

E-mail address: _____

Occupation: _____

Relationship status: Married__ Common Law__ Single__ Widowed__

Divorced__ Separated__ Same Sex__

Name of spouse: _____

Next of kin or other to reach in an emergency:

Name: _____ Relationship: _____

Phone: _____

CareCard Number: _____

Are you on premium assistance (MSP)? Yes__ No__

Do you have an active WCB or ICBC claim? Yes__ No__

Who is your general practitioner (MD)? _____

Are you currently seeing a medical specialist? Yes__ No__

Name of specialist _____

Do you have any known contagious diseases at this time? Yes__ No__

If yes, what? _____

How did you find out about our clinic?

__Internet/ website

__Canpages/ Yellowpages

__Referral from: _____

__Other _____



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Current Health Condition

What is the main reason for your visit today? _____

What are your most important health concerns?

- _____
- _____
- _____
- _____

Has anything recently changed or become worse? _____

Current Medications (prescription as well as over-the-counter): _____

Vitamins, Supplements, Herbs, Homeopathic remedies: _____

Known Allergies (to medications, food, pollens etc.): _____

Blood Type: A ___ B ___ AB ___ O ___

Health History

Height: _____ Weight: _____ Weight 1 year ago: _____

Max. weight _____ When? _____ Min. weight _____ When? _____

Childhood illnesses:

- | | | |
|---|---------------------------------------|--|
| <input type="checkbox"/> Chicken pox | <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps |
| <input type="checkbox"/> German measles | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Rheumatic fever |
| <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Asthma | <input type="checkbox"/> Whooping cough |
| <input type="checkbox"/> Scarlet fever | <input type="checkbox"/> Strep throat | <input type="checkbox"/> Ear infections |
| <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Other: _____ | |

Immunizations:

- | | | |
|--|-------------------------------------|---|
| <input type="checkbox"/> Measles/ Mumps/ Rubella | <input type="checkbox"/> Diphtheria | <input type="checkbox"/> Pertussis |
| <input type="checkbox"/> Hep B | <input type="checkbox"/> Polio | <input type="checkbox"/> Haemophilus influenza type B |
| <input type="checkbox"/> Flu | <input type="checkbox"/> Tetanus | Date of last tetanus shot: _____ |
| <input type="checkbox"/> Other (ex. for travel): _____ | | |



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Surgeries and Hospitalizations (list and give date or age): _____

The general state of my health is: ___excellent ___good___average___fair___poor

Energy level: ___/10 (10 = excellent, 0 = very poor)

Stress level: ___/10 (10= extremely stressed, 0 = no stress)

Lifestyle	Daily	Weekly
Tobacco	_____	_____
Alcohol	_____	_____
Drugs	_____	_____
Coffee	_____	_____
Other caffeine	_____	_____
Dairy products	_____	_____
Sweets	_____	_____
Exercise	_____	_____

Are there any foods/ food groups that you avoid? Please list: _____

Please check any of the following conditions that pertain to you, including any significant past health concerns (for past ones write "P"):

SKIN

- | | | |
|------------------------|----------------|-------------------|
| ___Rashes | ___Acne/ boils | ___Itching |
| ___Growths/ lumps | ___Hives | ___Colour changes |
| ___Excessive hair loss | ___Dry skin | ___Nail changes |

HEAD

- | | | |
|----------------------|--------------|------------------|
| ___Headaches | ___Migraines | ___Head injuries |
| ___Jaw/ TMJ problems | | |

EYES

- | | | |
|--------------------|-----------------------|---------------------------|
| ___Impaired vision | ___Blurriness | ___Colour blindness |
| ___Double vision | ___Tearing or dryness | ___Cataracts |
| ___Glaucoma | ___Eye strain/ pain | ___Wear glasses/ contacts |

EARS

- | | | |
|----------------------|--------------------|-------------|
| ___Impaired hearing | ___Ringing in ears | ___Earaches |
| ___Use a hearing aid | | |



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NOSE and SINUSES

- | | | |
|--|---|--------------------------------------|
| <input type="checkbox"/> Frequent colds | <input type="checkbox"/> Hayfever | <input type="checkbox"/> Nose bleeds |
| <input type="checkbox"/> Sinus problems | <input type="checkbox"/> Loss of sense of smell | |
| <input type="checkbox"/> Stuffiness or post-nasal drip | | |

MOUTH and THROAT

- | | | |
|--|--|--|
| <input type="checkbox"/> Frequent sore throat | <input type="checkbox"/> Excess saliva | <input type="checkbox"/> Teeth grinding |
| <input type="checkbox"/> Gum problems | <input type="checkbox"/> Hoarseness | <input type="checkbox"/> Dry mouth |
| <input type="checkbox"/> Root canal(s) | <input type="checkbox"/> Dental cavities | <input type="checkbox"/> Sore lips or tongue |
| <input type="checkbox"/> Silver/mercury amalgam fillings | | <input type="checkbox"/> Wear dentures |

RESPIRATORY

- | | | |
|---|-------------------------------------|--|
| <input type="checkbox"/> Cough | <input type="checkbox"/> Wheezing | <input type="checkbox"/> Asthma |
| <input type="checkbox"/> Emphysema | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Spitting up blood |
| <input type="checkbox"/> Difficult/ painful breathing | | <input type="checkbox"/> Positive TB test |

CARDIOVASCULAR

- | | | |
|---|--|---|
| <input type="checkbox"/> Heart disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Low blood pressure |
| <input type="checkbox"/> Murmurs | <input type="checkbox"/> Angina | <input type="checkbox"/> Palpitations/ fluttering |
| <input type="checkbox"/> Blood clots | <input type="checkbox"/> Chest pain | <input type="checkbox"/> High cholesterol |
| <input type="checkbox"/> Swelling in ankles | <input type="checkbox"/> Rheumatic fever | <input type="checkbox"/> Arrhythmia |

GASTROINTESTINAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Difficult swallowing | <input type="checkbox"/> Reflux | <input type="checkbox"/> Heartburn |
| <input type="checkbox"/> Nausea | <input type="checkbox"/> Vomiting | <input type="checkbox"/> Change in appetite |
| <input type="checkbox"/> Belching | <input type="checkbox"/> Excess gas | <input type="checkbox"/> Abdominal bloating |
| <input type="checkbox"/> Abdominal pain or cramping | | <input type="checkbox"/> Ulcer |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Diarrhea/ loose stools | <input type="checkbox"/> Blood with stool |
| <input type="checkbox"/> Hemorrhoids | <input type="checkbox"/> Jaundice | <input type="checkbox"/> Liver disease |
| <input type="checkbox"/> Gallbladder disease | <input type="checkbox"/> Eating disorder | <input type="checkbox"/> Hernia |

URINARY

- | | | |
|---|--|---|
| <input type="checkbox"/> Painful urination | <input type="checkbox"/> Increased frequency | <input type="checkbox"/> Frequency at night |
| <input type="checkbox"/> Bladder infections | <input type="checkbox"/> Inability to hold urine | <input type="checkbox"/> Kidney stones |

MUSCULOSKELETAL

- | | | |
|--|------------------------------------|--|
| <input type="checkbox"/> Joint pain or stiffness | <input type="checkbox"/> Arthritis | <input type="checkbox"/> Broken bones |
| <input type="checkbox"/> Weakness | <input type="checkbox"/> Sciatica | <input type="checkbox"/> Whiplash |
| <input type="checkbox"/> Back pain | <input type="checkbox"/> Neck pain | <input type="checkbox"/> Muscle cramps/ spasms |



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BLOOD/ PERIPHERAL VASCULAR

- | | | |
|---|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Varicose veins | <input type="checkbox"/> Easy bleeding/bruising |
| <input type="checkbox"/> Cold hands/ feet | <input type="checkbox"/> Deep leg pain | <input type="checkbox"/> Thrombophlebitis |

ENDOCRINE

- | | | |
|---|--|--|
| <input type="checkbox"/> Thyroid problems | <input type="checkbox"/> Hypoglycemia | <input type="checkbox"/> Diabetes |
| <input type="checkbox"/> Excessive thirst | <input type="checkbox"/> Excessive hunger | <input type="checkbox"/> Fatigue |
| <input type="checkbox"/> Night sweats | <input type="checkbox"/> Seasonal depression | <input type="checkbox"/> Heat or cold intoleranc |

IMMUNE

- | | | |
|---|---|--|
| <input type="checkbox"/> Chronic infections | <input type="checkbox"/> Slow wound healing | <input type="checkbox"/> Reactions to vaccines |
| <input type="checkbox"/> Chronically swollen glands | | |

MENTAL/ EMOTIONAL

- | | | |
|---|---|---|
| <input type="checkbox"/> Memory problems | <input type="checkbox"/> Poor concentration | <input type="checkbox"/> Anxiety/ nervousness |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Mood swings | <input type="checkbox"/> Suicidal thoughts |
| <input type="checkbox"/> Treated for emotional problems | | |

FEMALE REPRODUCTIVE

- Age at first menses: _____ Age at last menses (if menopausal): _____
 Length of cycle: _____ Date of last Pap: _____
 Number of pregnancies: _____ Number of live births: _____

Are you currently pregnant? Yes **No** **Not sure**

- | | | |
|--|--|--|
| <input type="checkbox"/> Irregular cycles | <input type="checkbox"/> Spotting | <input type="checkbox"/> Premenstrual syndrome |
| <input type="checkbox"/> Menstrual cramps | <input type="checkbox"/> Heavy flow | <input type="checkbox"/> Menopausal symptoms |
| <input type="checkbox"/> Vaginal discharge | <input type="checkbox"/> Breast lumps | <input type="checkbox"/> Breast pain/ tenderness |
| <input type="checkbox"/> Nipple discharge | <input type="checkbox"/> Abnormal Pap test | <input type="checkbox"/> Cervical dysplasia |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Ovarian cysts | <input type="checkbox"/> Uterine fibroids |
| <input type="checkbox"/> Sexually active | <input type="checkbox"/> Painful intercourse | <input type="checkbox"/> Sexual difficulties |
| <input type="checkbox"/> Sexually transmitted infections | | <input type="checkbox"/> Difficulty conceiving |
| <input type="checkbox"/> Birth control - Type: _____ | | |

MALE REPRODUCTIVE

- | | | |
|--|--|--|
| <input type="checkbox"/> Hernia | <input type="checkbox"/> Testicular masses | <input type="checkbox"/> Testicular pain |
| <input type="checkbox"/> Prostate disease | <input type="checkbox"/> Discharge or sores | <input type="checkbox"/> Sexually active |
| <input type="checkbox"/> Impotence | <input type="checkbox"/> Sexual difficulties | |
| <input type="checkbox"/> Sexually transmitted infections | | |
| <input type="checkbox"/> Birth control - Type: _____ | | |
| Date of last prostate exam: _____ | | |



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NEUROLOGICAL

- | | | |
|---|-----------------------------------|---|
| <input type="checkbox"/> Fainting | <input type="checkbox"/> Seizures | <input type="checkbox"/> Paralysis |
| <input type="checkbox"/> Numbness/ tingling | <input type="checkbox"/> Tremor | <input type="checkbox"/> Vertigo/ dizziness |

Is there anything else you would like to add about your health history?

Family Medical History: Please check areas pertaining to blood relatives (do not include yourself)

- | | | |
|---|--|---|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Hayfever, allergies | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart disease | <input type="checkbox"/> Substance abuse |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Thyroid problems |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Liver disease | <input type="checkbox"/> Other (please list): |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Kidney problems | _____ |
| <input type="checkbox"/> Eating disorders | <input type="checkbox"/> Mental disorders | _____ |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Obesity | _____ |

Goals: Please list any goals you have in regards to your health and wellbeing that we can assist you in reaching

- _____
- _____
- _____
- _____
- _____

Commitment:

How willing are you to make changes in your life in order to reach your health goals?

____/10 (10 = fully committed, 0 = not willing to change)

Thank you for taking the time to complete this questionnaire. We look forward to assisting you in improving your health and wellbeing.