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Regina, SK S4X 4J7

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PATIENT INTAKE FORM

Full Name: ____

Date of birth (dd/mm/yyyy): ______________ Age: __________ Sex: M F

Full address: ____

Email address: ____________________________________

Telephone: (home) ____________ (work) ____________(cell) ______________

May we leave messages relating to your visits? Y / N

Emergency Contact: ______________________________ (____)________

Full Name Relation Telephone

Name of Medical Doctor: ____________________ Tel: (_____)__________

Date of last visit to a Medical Doctor: __________ Date of last physical: __________

Other health care providers you are seeing:

1. ____________________ 2. ____________________ 3. ____________________

____________________ ____________________ ____________________

____________________ ____________________ ____________________

(_____)______________ (_____)______________ (_____)______________

Extended Health Care Carrier (if applicable): ____________________

How or by whom were you referred to this clinic? ______________________________

Have you been treated by a Naturopathic Doctor (ND) before? Y N

If yes, by whom? ______________________________ When? ______________

Health Concerns

What is your primary health concern?

____

____

How long have you had this condition? _________________

What specialist(s) have you seen, if any?

____

____

How has this condition been treated until now?

____

____

Can you trace the origin of the present illness to any particular circumstances, accident, illness, incident, mental upset or unusual stress in you life? If yes, please explain.

____

____

Additional Health Concerns and Health Goals

What else would you like to see changed in your health? List all other health concerns or goals in order of importance to you. Indicate the month and year each particular health concerned started, if possible.

	Health Concern/Goals	Month/Year	Present Treatment/Comments
1			
2			
3			
4			
5			

How would you describe your general state of health? Excellent Good Fair Poor

How long has it been since you experienced excellent health? _________________

Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remains as a weak point in our body's system. Homeopathic medicine takes into account details of the past and will work to eliminate these weak points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

Medical History

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

____
____
____
____
____

Please list any known allergies (medicines, environmental, etc.):

____
____
____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

____
____
____
____

Please list past prescription medications.

____
____
____

Approximately how many times have you been treated with antibiotics? ________________

Please list all immunizations that you have received:

Please check	√	**Please check**	√
Measles Mumps Rubella (MMR)		Tetanus booster	
Diphtheria Pertussis Tetanus (DPT)		Hepatitis A	
Polio		Hepatitis B	
H. influenza B		Flu vaccine	
Small pox		Chicken pox	
Yellow fever		Typhoid	
Other:		Other:	

Was there any serious reaction to any of the above vaccinations? (please explain)

____
____

Family History

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

☐ I don't know my family medical history

Personal Profile

Height: ____________ Present weight: __________________ Goal weight: _______

If your present weight is different than your desired weight, how long has it been since you were your normal or goal weight? ___________________________

Marital status: _______________How long have you been married (if applicable)? _____________

Number of Children (if applicable): _____________________

Occupation: ____

Average number of hours worked in a week: ____________

Stress of your work (0 none, 10 extremely stressful): _________________________________

Do you like your work? Y N

If No, why not? ____

What are your hobbies?____

____

Personal Habits and Lifestyle

Do you frequently use any of the following? (circle)

Aspirin / Laxatives / Antacids / Diet pills / Birth control pills/implants/injections

Alcohol—how much/day or week ______________________________

Tobacco—form and amount/day ______________________________

Caffeine—form and amount/day______________________________

Recreational drugs—what and how often______________________________

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

____

____

____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Dietary Habits

Diet: Non Vegetarian ☐ Vegetarian ☐ Vegan ☐ For how long? ____________

Do you have any food allergies or intolerances? Please list.

____

____

____

Describe a typical day's diet:

Breakfast ______________________________

Lunch______________________________

Dinner______________________________

Snacks ______________________________

Beverages (and total quantity) ______________________________

Is there anything that you feel is important that has not been covered?

____

____

____

Thank you! It's time for your healing journey to begin…