



PATIENT INTAKE FORM

Please ensure the information that you provide is accurate and complete. If you are here to for an initial visit please complete entire form. All information collected is considered confidential and is kept in accordance with the College of Naturopathic Physicians of BC.

Name _____ M F Birth Date (dd/mm/yy) ____/____/_____
Occupation/Previous Occupation _____
Family Physician (MD) _____ Phone _____

HEALTH OBJECTIVES: Wellness/Prevention Please contact me for annual check-ups as well Complaint Oriented
 I am here for a predetermined reason only and forgo any visit with a doctor. (In this case you may skip all grey text.)
MAIN HEALTH CONCERNS With Date of Onset (list in order of importance)

Have you been given any diagnosis? If so, what? _____
Have you had any lab work done or special studies (CT, MRI, Echocardiogram)? _____
What treatments have you tried and what were the outcomes _____

ALLERGIES/SENSITIVITIES _____
MEDICATION/SUPPLEMENTS: _____

YOUR MEDICAL HISTORY: Autoimmune disease Cancer Diabetes Heart Disease Hepatitis HIV
 High/Low Blood Pressure Rheumatic Fever Seizures Tuberculosis Stroke Pregnant (or planning to be)
 Kidney or bladder disease Venereal Disease Thyroid Disease Mental illness Nursing
 Other conditions: _____
 Exposure to harmful chemicals, radioactivity, fumes or other health hazards? Describe: _____
Any Hospitalizations, Surgeries, Implants etc. including date _____
Describe any significant stress in your life, e.g. schooling, residence, finances, relationships, etc. _____

Current weight _____ **Weight 1 year ago** _____ **Ideal weight** _____

HABITS
 Tobacco # of cigarettes /d _____ Alcohol # of drinks/week _____ Caffeine #6 oz coffee/d _____

EXERCISE
Days per week _____ Duration : _____ minutes Describe _____

DIET
Amount of Water per day _____ # of pop/week _____
 Mixed food diet Vegetarian Salt restriction Vegan
Restrictions: Dairy Wheat Eggs Soy All gluten

EATING HABITS: Skip meals Eat on the run
 Small frequent meals Cravings for: _____

FAMILY MEDICAL HISTORY (Parents and Siblings)
 Arthritis Alcoholism Alzheimer's disease
 Depression Asthma Diabetes Cancer
 Drug Addiction Glaucoma Genetic disorder
 Heart Disease Infertility Mental illness
 Migraine Obesity Thyroid Disorders

GENERAL
 Fatigue/Time of Day _____ Poor sleep
 Bleed or bruise easily Poor appetite Fevers
 Increased appetite Chills Tremors
 Cravings Sweat easily Dizziness
 Cold hands or feet Strong thirst

SKIN AND HAIR
 Sensitive Skin Ulcerations Hives Itching
 Eczema Acne Dandruff Warts
 Hair Loss Suspicious Moles or Lesions Rashes

INDICATE PAINFUL OR DISTRESSED AREAS
 X – sharp/intense pain O- dull/ aching
 /- radiating pain N- numbness/ tingling
 S- area of surgery W-Weakness



PATIENT INTAKE FORM

MUSCULOSKELETAL

- Whiplash
- Osteoarthritis
- Osteoporosis
- Rheumatoid Arthritis
- Re-occurring Sprains/Strains
- Tendonitis
- Bursitis
- Dislocations
- Fracture

HEAD, EYES, EARS, NOSE AND THROAT

- Concussions
- Migraines
- Eye pain
- Glasses or contact lenses
- Eye strain
- Cataracts
- Poor vision
- Night blindness
- Blurry vision
- Spots in front of eyes
- Earaches or infections
- Ringing in ears
- Poor hearing
- Sinus Problems
- Recurrent sore throats
- Nosebleeds
- Grinding teeth
- Sores on lips or tongue
- Jaw clicks
- Teeth problems
- Headaches
- _____ # of amalgam fillings (Mercury/Silver)

CARDIOVASCULAR

- Fainting
- Chest pain
- Phlebitis
- Congestive Heart Failure
- High/Low blood pressure
- Irregular heartbeat
- Swelling of hands/ feet
- Blood clotting disorders
- Varicose veins

RESPIRATORY

- Cough
- Asthma
- Emphysema
- Bronchitis
- Pneumonia
- Shortness of Breath
- Phlegm (what color)?

GASTROINTESTINAL

- Nausea
- Heartburn/Reflux
- Indigestion
- Vomiting
- Belching
- Blood in stools
- Constipation
- Gas
- Rectal pain
- Diarrhea
- Bad breath
- Hemorrhoids
- Abdominal pain or cramps
- Chronic laxative use
- Black stools
- Ulcers/Gastritis

GENITO-URINARY

- Pain on urination
- Frequent urination
- Blood in urine
- Urgency to urinate
- Unable to hold urine
- Kidney stones
- Decrease inflow
- Erectile Dysfunction
- Sores on genitals
- Do you wake to urinate (how often)?

WOMEN'S HEALTH

- Menstrual Irregularities
- Light/Heavy
- Clots
- Painful periods
- Endometriosis
- Premenstrual Syndrome
- Fibrocystic Breasts
- Breast cancer
- Ovarian cysts
- Pelvic Inflammatory Disease
- Decreased sex drive
- Menopause
- Infertility
- Vaginal infections
- Oral contraception, type: _____

of children: _____ # of pregnancies: _____ Date of last PAP exam _____
 Date of last mammogram: _____ Date of last Menstrual Period _____ Date of Last Thermography _____

MEN'S HEALTH

- Benign prostatic enlargement
- Prostate Cancer
- Decreased sex drive
- Erectile Dysfunction

NEUROPSYCHOLOGICAL

- Seizures
- Panic Attacks
- Lack of coordination
- Poor memory
- Depression
- Anxiety
- Quick temper / irritable

Please indicate any other problems you would like to discuss _____

I am also interested in:

- Modifiable Genetic Risk factors for diseases such as cancer, cardiovascular disease and osteoporosis
- Heavy metal testing for mercury, cadmium, lead, arsenic, and other common toxic metals
- Determining underlying factors that cause difficult weight loss such as cortisol, thyroid function, serotonin, estrogen and testosterone
- Salivary hormone assessments for estrogen, progesterone, DHEA, DHT, etc.
- Metabolic assessment for nutritional status i.e. need for certain vitamins, minerals, essential fats
- Food and/or environmental sensitivity and allergy testing

I confirm that I have given all relevant information to the best of my knowledge.

 (Signature of Patient, Parent or Legal Guardian)

 (Date)