NATUROPATHIC INTAKE FORM

PLEASE COMPLETE THIS FORM FOR YOUR NATUROPATH (PRINT OR EDIT ELECTRONICALLY)

Name _____ Today's Date _____ / _____ / _____
MM DD YYYY

Date of Birth _____ / _____ / _____
MM DD YYYY

General State Of Health: ❑ Excellent ❑ Good ❑ Fair ❑ Poor

Age _____ Gender _____ Weight _____ Height _____

Address _____ Apt./Unit # _____

City _____ Province _____ Postal Code _____

Phone _____ Cell _____ Work _____ Email _____

Emergency Contact _____ Relationship _____ Phone _____

Family Doctor & Other Health Care Providers you are seeing:

Name _____ Name _____

Specialty _____ Specialty _____

Phone _____ Phone _____

Date of Last Visit _____ Date of Last Visit _____

Have you ever consulted (Please check all that apply):

❑ Naturopathic Doctor ❑ Chiropractor ❑ Counselor ❑ Dietician ❑ Holistic Nutritionist

Last time you had blood work done and any noteable concerns _____

_____

MEDICAL INFORMATION

Allergies, if known (medical, environmental, foods) _____

_____

Dietary restrictions, if any (vegetarian / vegan / keto) _____

_____

Current medication/s & dosage _____

_____

Supplements & dosage (vitamins & herbs) _____

_____

Past prescriptions / medications _____

_____

Past serious conditions, illnesses, injuries and/or hospitalizations & dates

_____

_____

Family Health History: Has a close relative (parent, grandparent, sibling) had any of the following?

❑ Arthritis	❑ Eczema	❑ Kidney Disease	❑ Skin Disease
❑ Asthma	❑ Endometriosis	❑ Mental Illness	❑ Stroke
❑ Diabetes	❑ Gallstones	❑ Multiple Sclerosis	❑ High Blood Pressure
❑ Cancer (Type/s):	❑ Heart Disease	❑ Osteoporosis	❑ PMS

_____

Other: _____

Please list your health concerns, in order of importance to you:

1. _____ 2. _____

3. _____ 4. _____

5. _____ 6. _____

GENERAL HEALTH INFORMATION

Do you use any of the following? List the type and frequency if applicable:

Alcohol _____ Antacids _____ Caffeine _____

Laxatives _____ Cigarettes _____ Tylenol, Aspirin or Advil _____

Other _____

Number of antibiotic treatments in last 5 yrs: _____

Are you currently pregnant? ❑ Yes ❑ No ❑ N/A

Do you get regular screening tests done by another doctor? (pap, blood tests, BMI, etc.) ❑ Yes ❑ No

Have you ever had an abnormal pap, if applicable: ❑ Yes ❑ No ❑ N/A

Are you regularly or have you ever been regularly exposed to:

solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

_____

_____

Are you particularly sensitive to perfumes, gasoline or other vapours (new furniture, carpets, paints etc.)? ❑ Yes ❑ No

Are you frequently exposed to animals (work, pets, etc.)? _____

How is your home heated?_____

DAILY ENVIRONMENTS

Occupation _____

Hobbies _____

How would you describe the emotional climate of your home?

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

Do you exercise regularly? ❑ Yes ❑ No

What do you do for exercise, how much, how often? _____

_____

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

_____

_____

_____

PRIVACY

INFORMED CONSENT FOR COMMUNICATION

Your Canadian Naturopath will value your relationship and may need this information to be submitted electronically. They will need your consent to do so and to also send you any electronic messagesin the form of appointment reminders, newsletters, upcoming events and other clinic information. Please take a moment to select either "OPT IN" or "OPT OUT". Opting in will provide your chosen Naturopathic Doctor consent to communicate with you electronically. Opting out will indicate that you do not wish to receive any electronic communication from them.

❑ **OPT IN** ❑ **OPT OUT**

Signature _____ Date _____ / _____ / _____
MM DD YYYY

Thank you for taking the time to complete this form, we wish you the best in optimizing your health and well being.