

**PATIENT INTAKE FORM - ADULT**

Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

Telephone (h): \_\_\_\_\_ (w): \_\_\_\_\_ Email: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Age: \_\_\_\_\_ Male [  ] Female [  ]

Family/Home Status: (single, live with friends, married, single parent, etc.)

Height: \_\_\_\_\_ Weight: \_\_\_\_\_ Blood Type: \_\_\_\_\_

Family Doctor: \_\_\_\_\_ phone: \_\_\_\_\_

Chiropractor: \_\_\_\_\_ phone: \_\_\_\_\_

Other Health Care Provider (please specify what treatment they provide):

Past Naturopathic Doctor: \_\_\_\_\_

Emergency Contact Person: \_\_\_\_\_

Relation: \_\_\_\_\_ Phone (home): \_\_\_\_\_ (work): \_\_\_\_\_

Known Diseases: \_\_\_\_\_

Known Allergies: \_\_\_\_\_

Please state why you have chosen Naturopathic Medicine: \_\_\_\_\_

Chief Health Concerns (In order of importance):

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

Detailed history of your primary health concern (onset, pertinent dates and procedures if any): \_\_\_\_\_

Referred to us by: \_\_\_\_\_

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset, or unusual stress in your life? Explain. \_\_\_\_\_

In regards to your chief complaint, please list what treatments, regimes, diets, and therapies, if any, have brought real improvement or relief? \_\_\_\_\_

Which have brought no improvement or relief? \_\_\_\_\_

Do you use any of the following?

- COFFEE OR BLACK TEA | AMOUNT: \_\_\_\_\_
- TOBACCO | # DAILY: \_\_\_\_\_
- SODA POP/ CARBONATED BEVERAGE | AMOUNT: \_\_\_\_\_
- LIQUOR / BEER / WINE | AMOUNT: \_\_\_\_\_
- ALKISELSER/ TUMS/ ETC. | AMOUNT: \_\_\_\_\_
- MARGARINE TYPE: \_\_\_\_\_
- PROCESSED FOODS TYPE: \_\_\_\_\_
- RECREATIONAL DRUGS TYPE: \_\_\_\_\_
- LAXATIVES TYPE: \_\_\_\_\_
- ASPARTAME # PRODUCTS | DAILY: \_\_\_\_\_

Do you exercise? (Include type, frequency, duration, and intensity): \_\_\_\_\_

Do you have a problem with addiction: yes [ ] no [ ]

Type: Food [ ] Alcohol [ ] Drugs [ ] Other: \_\_\_\_\_

Hours a day you spend: Working: \_\_\_\_\_ Sleeping: \_\_\_\_\_ Watching TV: \_\_\_\_\_

Recreation (not TV): \_\_\_\_\_ Doing something you love: \_\_\_\_\_

What is your STRESS LEVEL (10 = High Stress)

1 2 3 4 5 6 7 8 9 10

What is your main stressor? \_\_\_\_\_

How would you describe your daily mood and energy? \_\_\_\_\_

List all the Food Supplements, Health Products, and Prescription Drugs you are currently taking. Use the other side of this sheet if needed.

PRODUCT	DOSAGE	WHY	SINCE	WHEN

Have you had any of your organs surgically removed? Which one(s)?

List any significant traumas you have lived through. (Car accident, injuries, surgery, divorce, death of a loved one, ...)

What was your childhood like? \_\_\_\_\_

Please list your offspring and their ages:  
Children: \_\_\_\_\_ Grandchildren: \_\_\_\_\_

CONTEXT OF CARE

What 3 expectations do you have from your first visit?

- 1) \_\_\_\_\_
- 2) \_\_\_\_\_
- 3) \_\_\_\_\_

What long-term expectations do you have from working with our clinic?

What expectations do you have of me personally, as your physician?

Thank you for providing me with this information.  
I look forward to serving you in the best ways I am able.

CANCELLATION POLICY

Please ensure to give 2 business days cancellation notice. For appointments cancelled on the same day, full cost of the appointment will be charged. For those cancelled with only 1 business days notice, 50% of the appointment fee will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Centre for Natural Medicine.

Please sign that you have read and agree to the cancellation policy as written above:

Signature: \_\_\_\_\_ Date: \_\_\_\_\_