Naturopathic Medicine
Phone: 905 840 9355
220 Wexford Rd Unit 2, Brampton ON L6Z 4N7

Intake Form

Name: _____ Date: _____

Date of Birth: _____ Gender: M / F

Address: _____

Email Address: _____

Telephone Number Home: _____Cell: _____

Work: _____

May we leave you a message at any of these phone numbers? Y / N Which one: _____

May we email you regarding your care? Y / N

Emergency Contact Name: _____

Relationship: _____ Telephone Number: _____

How did you hear about Naturopathic Medicine at the Justine Blainey Wellness Centre?

_____

Other Health Care Providers that you are currently seeing:

Name	Designation/Specialty	Phone Number

Have you previously seen a Naturopathic Doctor? _____

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This is a confidential record of your health history and will be kept in this office. Information contained in this document will not be released to any other person except when you have authorized us to do so in writing. Please complete this questionnaire as thoroughly as possible.

Health Concerns

Please list your health concerns or goals in order of importance and any diagnosis that has been made

Concern	Diagnosis, if applicable
1.	
2.	
3.	
4.	
5.	

If you are a woman, are you pregnant? Y / N

Medical History

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

Previous illnesses, conditions, injuries or hospitalizations:_____
_____
_____
_____
_____
_____
_____

Known allergies (medication, environmental): _____
_____

Current Medications (prescription and over-the-counter):

Name of Medication	Dose	Length of time taken

Name: _____ Date: _____

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Current Vitamins, Mineral, Herbs, Homeopathics that you take more than occasionally:

Name of Supplement & Brand	Dose	Length of time taken

Past Medications and Supplements taken for longer than 3 months:

Name	Dose	Length of time taken

Past adverse reactions to medication: _____

Immunizations: ☐ DPT ☐ Hemophilus Influenza B ☐ MMR ☐ Hepatitis A ☐ Hepatitis B ☐ Flu Shot ☐ Tetanus most recent: _____ ☐ HPV ☐ Polio ☐ Smallpox ☐ Other _____

Do you do regular screening tests with another doctor (ex. Pap smear, blood tests): Y / N

Date of most recent physical exam: _____

Weight: _____ Height: _____Weight 1 year ago: _____Max weight: _____When: _____

Family Medical History

Has a parent, grandparent, sibling or child been diagnosed with any of the following conditions?

Condition	**Relative**
Alcoholism/Addiction	
Allergies	
Anemia	
Anxiety	
Arthritis	
Asthma	
Back Pain	
Cancer	
Diabetes	
Eczema	
Epilepsy	
Depression	

Condition	**Relative**
High Blood Pressure	
Heart Disease	
Hepatitis/ Liver Disease	
Headaches	
Kidney Disease	
Lung Problems	
Stroke	
Tuberculosis	
Osteoporosis	
Other Mental Illness	
Other	

Name: _____ Date: _____

Personal Health Habits/Lifestyle

Cigarette smoking: Y / N Amount per Day: _____Years smoked: _____

Second-hand smoke: Y / N _____

Alcohol use: # of drinks per week _____

Recreational drug use: _____

Daily intake: Coffee_____ Black tea_____ Soda _____ Energy drinks _____

Dietary restrictions: _____

Food allergies or intolerances: _____

Occupation: _____Hours of work per day: _____

Do you enjoy your work?_____

Hobbies: _____

What do you LOVE to do? _____

Hours spent outdoors per week: _____Activities: _____

Hours of sleep per night: _____Do you wake feeling rested? _____

Do you exercise regularly: Y / N Minutes per week: _____

Types of exercise: _____

Emotional climate of your home: _____

Stress level: Minimal Average Considerable Unbearable

Anything else that you feel is important that has not been covered:

_____

_____

_____

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Your Naturopathic Care

What expectations do you have for your care? _____

_____

What expectations do you have for me personally as your Naturopathic Doctor? _____

_____

What is your present level of commitment to addressing the lifestyle factors that may be underlying your health concerns? (Lowest) 1 2 3 4 5 6 7 8 9 10 (Highest)

What behaviours and lifestyle habits do you regularly engage in that you believe support your health?

_____

_____

What behavious and lifestyle habits do you regularly engage in that you believe have a negative impact on your health? _____

_____

What potential obstacles could affect your ability to make changes to your lifestyle habits and to follow your treatment plan? _____

_____

Who do you know who will sincerely support you with the beneficial lifestyle changes you will be making? _____

_____

Name: _____ Date: _____

Symptom Review

Check "Y" if you have a symptom currently or "P" if you have had it in the past

General	Y	P
Fatigue		
Fever/Chills		

Skin	Y	P
Rashes		
Hives		
Eczema		
Acne		
Itching		
Boils		
Lumps		
Night Sweats		
Excessive sweating		
Dry Skin		
Other:		

Head	Y	P
Headache		
Head injury		
Dizziness		
Other:		

Ears	Y	P
Impaired Hearing		
Ear pain		
Discharge		
Infections		
Excessive wax		
Other:		

Nose/Sinuses	Y	P
Frequent colds		
Nose bleeds		
Stuffiness		
Hay fever		
Sinus problems		
Other:		

Eyes	Y	P
Impaired vision		
Glasses/Contacts		
Eye Pain		
Tearing		
Dryness		
Double vision		
Blurred vision		
Glaucoma		
Cataracts		
Itching		
Redness		
Discharge		
Blind spot		
Other:		

Mouth/Throat	Y	P
Frequent sore throats		
Hoarseness		
Gum Problems		
Difficulty Swallowing		
Dental Problems		
Gum problems		
Sores		
Dryness		
Loss of taste		
Other:		

Neck	Y	P
Lumps		
Swollen Glands		
Goiter		
Pain or Stiffness		
Other:		

Respiratory	Y	P
Cough		
Coughing up mucus		
Coughing up blood		
Wheezing		
Asthma		
Bronchitis		
Pneumonia		
Pleurisy		
Emphysema		
Difficulty Breathing		
Pain on Breathing		
Shortness of Breath		
when lying down		
at night		
Tuberculosis		
Positive TB test		
Other:		

Cardiovascular	Y	P
Chest Pain		
Heart murmur		
Palpitations		
Swelling of ankles		
Past ECG		
Other:		

Breasts	Y	P
Do you do self exams?		
Lumps		
Pain/tenderness		
Nipple discharge		
Last mammogram:		
Other:		

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Gastrointestinal	Y	P
Heart Burn		
Change in thirst		
Change in appetite		
Nausea		
Vomiting		
Belching		
Passing gas		
Abdominal pain		
Indigestion		
Diarrhea		
Constipation		
Blood in stool		
Hemorrhoids		
Tarry, black stool		
Liver disease		
Gallbladder disease		
Hernias		
Last colonoscopy:		
Other:		

Urinary	Y	P
Pain with urination		
Increased frequency		
Frequency at night		
Inability to hold urine		
Frequent infections		
Kidney stones		
Blood in urine		
Reduced flow		
Other:		

Musculoskeletal	Y	P
Joint pain or stiffness		
Joint swelling		
Muscle spasms/cramps		
Weakness		
Back pain		
Other:		

Female	Y	P
Age of 1st menses		
Date of last menses		
Number of days of menses		
Length of cycle		
Irregular cycles		
Bleeding between periods		
Painful menses		
Excessive flow		
PMS		
Pain with Intercourse		
Number of Pregnancies		
Number of Live Births		
Number of Miscarriages		
Number of Abortions		
Difficulty conceiving		
Check Sexual Orientation		
Heterosexual		
Homosexual		
Bisexual		
Sexually active		
Sexual difficulties		
Vaginal Discharge		
Vaginal Itching		
Last Pap Smear:		
Other:		

Male	Y	P
Hernia		
Testicular Mass		
Testicular Pain		
Check Sexual Orientation		
Heterosexual		
Homosexual		
Bisexual		
Sexually active		
Sexual difficulties		
Discharge or sores		
Last Prostate exam:		

Peripheral Vascular	Y	P
Deep leg pain		
Cold hands/feet		
Varicose veins		
Leg cramps		
Numbness in hands/feet		
Swelling in hands/feet		
Leg/foot ulcers		
Easy bleeding/bruising		
Other:		

Neurological	Y	P
Fainting		
Seizures		
Paralysis		
Muscle weakness		
Numbness or tingling		
Involuntary movements		
Loss of balance		
Speech problems		
Loss of memory		
Insomnia		
Other:		

Emotional	Y	P
Depression		
Mood swings		
Anxiety		
Nervousness		
Tension		
Phobias		
Alcohol/drug use		
Psychological Counseling		
Other:		

Name: _____ Date: _____