



Naturopathic Intake Form

Personal Information

Date: _____

Name: _____ Age: _____ Birth

Date: ___dd/mm/yyyy___ Sex: _____

Address: _____ City: _____

Province: _____ Postal Code: _____

Telephone: (Home) _____ (Work) _____ (Cell) _____

Email: _____

Occupation: _____

Do you have private health insurance? Yes No

Marital Status: Married Single Widowed Divorced Separated Common Law

Number of Children: _____

Family Physician: _____

Phone Number: _____ Fax Number: _____

In Case of emergency contact: _____

Address: _____ Phone Number: _____

Relationship: _____

How did you hear about our clinic? _____

Have you seen a Naturopathic Doctor before? Yes No

If yes, for what reason(s)? _____



Current Health History

What is your major health concern? _____

How long have you had this condition? _____

What activities aggravate your condition? _____

Does your health concern interfere with any of the following?

___ Work ___ Sleep ___ Daily Routine ___ Other

Please list any other health concerns you have:

1. _____ 2. _____ 3. _____

How long has it been since you felt really good? _____

Please list all known allergies (medications, food, pollen, etc.):

Have you ever had any mental or emotional disorders? _____ If yes, when? _____

Please indicate how often you go for dental visits:

___ Every 6 Months ___ Yearly ___ Toothache or Emergency ___ Wear Dentures

What other therapies are you currently using? (Chiropractic, Physiotherapy, Acupuncture etc)

Medication and Supplement History

Please list all supplements, herbs and medications you are currently taking:

Medication/Supplement	Dosage	Since	Reason



History of antibiotic use: (last two years)

When: _____

How long: _____

For what condition(s):

+

Health History

Please indicate which of the following conditions you have had:

- | | | | | |
|--------------------------------------|---|--|--|---|
| <input type="checkbox"/> Abscesses | <input type="checkbox"/> Depression | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Scarlet Fever |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Hepatitis | <input type="checkbox"/> Mumps | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Emphysema | <input type="checkbox"/> Parasites | <input type="checkbox"/> Skin Disease | <input type="checkbox"/> Amnesia |
| <input type="checkbox"/> Influenza | <input type="checkbox"/> Peritonitis | <input type="checkbox"/> Strep Throat | <input type="checkbox"/> Sinusitis | <input type="checkbox"/> Typhoid |
| <input type="checkbox"/> Gall Stones | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Pleurisy | <input type="checkbox"/> Yellow Fever | <input type="checkbox"/> Warts |
| <input type="checkbox"/> Goiter | <input type="checkbox"/> Leukemia | <input type="checkbox"/> Pneumonia | <input type="checkbox"/> Sunstroke | <input type="checkbox"/> Epilepsy |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Malaria | <input type="checkbox"/> Prostatitis | <input type="checkbox"/> Tonsillitis | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Gout | <input type="checkbox"/> Measles | <input type="checkbox"/> Rheum. Fever | |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Miscarriage | <input type="checkbox"/> Rubella | <input type="checkbox"/> Tuberculosis | |

Please indicate if you have or have had any of the following symptoms:

GENERAL

- __ Allergies
- __ Chills
- __ Convulsions
- __ Dizziness
- __ Fainting
- __ Fatigue
- __ Headache
- __ Loss of sleep
- __ Weight Loss
- __ Nervousness
- __ Depression
- __ Neuralgia
- __ Sweats
- __ Tremors
- __ Swelling of Ankles

GASTROINTESTINAL

- __ Belching
- __ Colitis
- __ Colon Trouble
- __ Constipation
- __ Diarrhea
- __ Difficult Digestion
- __ Excessive Hunger
- __ Distension of Abdomen
- __ Gallbladder Trouble
- __ Hemorrhoids
- __ Jaundice
- __ Liver Trouble
- __ Nausea
- __ Poor Appetite
- __ Vomiting
- __ Vomiting of Blood

CADIOVASCULAR

- __ Hardening of the Arteries
- __ High Blood Pressure
- __ Low Blood Pressure
- __ Pain Over Heart
- __ Poor Circulation
- __ Rapid Heart Beat
- __ Chest Pain
- __ Slow Breathing

RESPIRATORY

- __ Difficult Breathing
- __ Chronic Cough
- __ Wheezing
- __ Spitting up Blood
- __ Spitting up Phlegm



Please indicate if you have or have had any of the following symptoms:

MUSCLES & JOINTS

- Arthritis
- Bursitis
- Foot Trouble
- Hernia
- Low Back Pain
- Lumbago
- Neck Pain/ Stiffness
- Shoulder Pain

PAIN OR NUMBNESS

- Elbows
- Feet
- Hands
- Hips
- Knees
- Legs
- Shoulders /Arms
- Tailbone

SKELETAL

- Backache
- Poor Posture
- Sciatica
- Spinal Curvature
- Swollen Joints

EYES, EARS, NOSE, THROAT

- Crossed Eyes
- Asthma
- Colds
- Deafness
- Dental Decay
- Ear Discharge
- Earache
- Enlarged Glands
- Enlarged Thyroid
- Eye Pain
- Failing Vision
- Far-Sightedness
- Near-Sightedness
- Gum Trouble
- Hay Fever
- Hoarseness
- Nasal Obstruction
- Nosebleeds
- Sinus Infection
- Sore Throat
- Tonsillitis

SKIN

- Bruise Easily
- Dryness
- Hives / Allergies
- Itching
- Rash
- Varicose Veins

GENITO-URINARY

- Bed-wetting
- Blood in Urine
- Frequent Urination
- Painful Urination
- Prostate Troubles

WOMEN

- Congested Breasts
- Cramps
- Excessive Menstrual Flow
- Lumps in Breast
- Menopausal Symptoms
- Painful Menstruation
- Vaginal Discharge
- Are You Pregnant?

Please indicate if you've had any hospitalizations, surgeries, or serious injuries:

Operation	When	Complications?

Injuries:

Injury	When	Long-Term Effects?



Diet and Lifestyle

How much of the following substances do you use on a daily basis? (Heavy, moderate light, or none)

Tobacco: _____ Alcohol: _____ Caffeine: _____ Soda Pop: _____
 Recreational Drugs: _____ Prescribed Medications: _____ Laxatives: _____
 Carbonated beverages: _____

Have you lost any weight lately? Yes No If yes, how many pounds? _____

Are you concerned about your weight? Yes No

Are you seeking guidance in nutrition and daily lifestyle? Yes No

Are there any foods or food groups that you avoid? Yes No

If yes, which ones and why?

How often do you engage in physical activity?

Daily ___ 2-3 times/week ___ once a week ___ less than once a week ___

What types of activities? _____

On average, how many hours of sleep do you get per night? _____

How many glasses of water do you drink per day? _____

Family Health History

Please indicate any relevant health conditions of your blood relatives only.

Relation	Past and Present Health Problems	Age at time of death (if applicable)



INFORMED CONSENT

The above information is true to the best of my knowledge. I understand that I am financially responsible for payment, upon service rendered. I also authorize The Nardella Clinic to release information required by my extended health care provider to process my claims. I acknowledge that I must give 48 hours notice for any cancellation or rescheduling of a booked appointment. If said notice is not given I acknowledge that a cancellation fee will be applied to the Credit Card number that I have provided at the time of initial booking. I further consent for my medical history to be used in an anonymous fashion to create clinic case studies.

Patient/Guardian signature

I would like to take this opportunity to welcome you to the clinic. This Clinic utilizes the principles and practices of Naturopathic Medicine and supplemental therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your practitioner will conduct a thorough case history, which may include a physical exam and specific laboratory testing as part of the treatment work-up. Any practitioner you choose to work with will have access to your history to minimize repetition while maintaining complete confidentiality.

Statement of Acknowledgement

I, (printed name) _____ as a patient of this clinic, have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. As the clinic is an integrated health clinic, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest of therapies potentially have their complications in certain physiological conditions, in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some Naturopathic treatments include, but are not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs, pain, fainting, bruising or injury from venipuncture or acupuncture; and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so declaring.

I accept full responsibility for any fees incurred during care and treatment.

SIGNATURE

DATE

WITNESS