



Please email, fax or mail in a copy of your intake form **2 days** before your initial visit.

How did you hear about our clinic?				
Name:	Gender identity:	Sex assigned at birth:	DOB:	Age:
Address:		City:	Province:	Postal Code:
Email:	Cell:	Home Tel:	Work Tel:	
Marital status: <input type="checkbox"/> Single <input type="checkbox"/> Partnered <input type="checkbox"/> Married <input type="checkbox"/> Separated <input type="checkbox"/> Divorced <input type="checkbox"/> Widowed		Occupation:		
Name of MD:		Date of last physical exam:		

PERSONAL HEALTH HISTORY

Childhood illness:	<input type="checkbox"/> Measles	<input type="checkbox"/> Mumps	<input type="checkbox"/> Rubella	<input type="checkbox"/> Chickenpox	<input type="checkbox"/> Rheumatic Fever	<input type="checkbox"/> Polio
Vaccinations:	Tetanus	<input type="checkbox"/>	Pneumonia	<input type="checkbox"/>		
	Hepatitis	<input type="checkbox"/>	Chickenpox	<input type="checkbox"/>		
	Influenza	<input type="checkbox"/>	MMR Measles, Mumps, Rubella	<input type="checkbox"/>		

Please list your primary health concerns or reason for visit:

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Surgeries and other hospitalizations

Year	Reason

List all medication you are taking, both OTC and prescribed

Name:	Dosage:	Reason:

List any vitamins, minerals, herbs or other supplement you are taking

Name:	Dosage:	Frequency Taken

Any known allergies?

Name:	Reaction:

HEALTH HABITS									
Exercise	Sedentary (No exercise)								
	Mild exercise (i.e., climb stairs, walk 3 blocks, golf)								
	Occasional vigorous exercise (i.e., work or recreation, less than 4x/week for 30 min.)								
	Regular vigorous exercise (i.e., work or recreation 4x/week for 30 minutes)								
Height/Weight	Current weight?		Ideal weight?			Height?			
Diet	Are there any foods that you avoid or restrict?								
	Are there any foods that you crave?								
	Do you regularly skip meals? Yes <input type="checkbox"/> No <input type="checkbox"/>								
	Describe your typical daily diet in the space below:								
	<u>Breakfast</u>								
	<u>Lunch:</u>								
	<u>Dinner:</u>								
	<u>Snacks:</u>								
	<u>Drinks (juice, pop, milk, etc):</u>								
How many glasses of water do you drink per day?									
Digestion	Do you experience? (check all that apply) <input type="checkbox"/> Gas <input type="checkbox"/> Bloating <input type="checkbox"/> Constipation <input type="checkbox"/> Diarrhea <input type="checkbox"/> Heartburn								
Energy	Rate your energy levels (scale of 1-10, 10 being the highest)				When is your energy highest?			Lowest?	
Sleep	How many hours per night?			Do you wake-up feeling refreshed? <input type="checkbox"/> Yes <input type="checkbox"/> No					
Caffeine	None <input type="checkbox"/>		Coffee <input type="checkbox"/>		Tea <input type="checkbox"/>		Cola <input type="checkbox"/>		
	# of cups/cans per day?								
Alcohol	Do you drink alcohol? <input type="checkbox"/> Yes <input type="checkbox"/> No				How many drinks per week?				
Tobacco	Do you smoke? <input type="checkbox"/> Yes <input type="checkbox"/> No				Packs/day			Year quit?	
Drugs	Do you currently use recreational or street drugs?							<input type="checkbox"/> Yes	<input type="checkbox"/> No
Sex	Are you sexually active?							<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If yes, are you trying for a pregnancy?							<input type="checkbox"/> Yes	<input type="checkbox"/> No
	If not trying for a pregnancy list contraceptive or barrier method used:								
	Any discomfort with intercourse?							<input type="checkbox"/> Yes	<input type="checkbox"/> No

FAMILY HEALTH HISTORY

AGE		SIGNIFICANT HEALTH PROBLEMS		AGE		SIGNIFICANT HEALTH PROBLEMS	
Father			Grandparent	M <input type="checkbox"/> F <input type="checkbox"/>			
Mother			Grandparent	M <input type="checkbox"/> F <input type="checkbox"/>			
Siblings	M <input type="checkbox"/> F <input type="checkbox"/>		Siblings	M <input type="checkbox"/> F <input type="checkbox"/>			

MENTAL HEALTH

Do you often feel stressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel depressed?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Are you overwhelmed by stress?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Does stress affect your sleep?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ASSIGNED FEMALE AT BIRTH

Age at onset of menstruation:

Date of last menstruation:

Period every ____ days

☐ Heavy periods ☐ Spotting ☐ Pain ☐ discharge? (check all that apply)

Number of pregnancies ____ Number of live births ____ Number of Miscarriages ____

Are you pregnant or breastfeeding?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a D&C, hysterectomy, or Cesarean?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any urinary tract, or yeast infections within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any problems with control of urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any hot flashes or sweating at night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
When did this start?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Experienced any recent breast tenderness, lumps, or nipple discharge?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a pap and breast exam within the last year?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

ASSIGNED MALE AT BIRTH

Do you usually get up to urinate during the night?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
If yes, # of times ____		
Do you feel pain or burning with urination?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any blood in your urine?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you feel burning discharge from penis?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Has the force of your urination decreased?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Do you have any problems emptying your bladder completely?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any difficulty with erection or ejaculation?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Any testicle pain or swelling?	<input type="checkbox"/> Yes	<input type="checkbox"/> No
Have you had a recent prostate and rectal exam?	<input type="checkbox"/> Yes	<input type="checkbox"/> No

PAST AND PRESENT MEDICAL HISTORY

Check N if you currently are experiencing and P if you have had it in the past

Now	Past	Condition	Now	Past	Condition	Now	Past	Condition
<input type="checkbox"/>	<input type="checkbox"/>	Allergies	<input type="checkbox"/>	<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	<input type="checkbox"/>	Asthma	<input type="checkbox"/>	<input type="checkbox"/>	Arthritis (including gout)	<input type="checkbox"/>	<input type="checkbox"/>	Migraines
<input type="checkbox"/>	<input type="checkbox"/>	Eczema	<input type="checkbox"/>	<input type="checkbox"/>	Thyroid problems	<input type="checkbox"/>	<input type="checkbox"/>	Headaches (tension/cluster)
<input type="checkbox"/>	<input type="checkbox"/>	Psoriasis	<input type="checkbox"/>	<input type="checkbox"/>	Anemia	<input type="checkbox"/>	<input type="checkbox"/>	Diabetes
<input type="checkbox"/>	<input type="checkbox"/>	Acne	<input type="checkbox"/>	<input type="checkbox"/>	High blood pressure	<input type="checkbox"/>	<input type="checkbox"/>	Pneumonia
<input type="checkbox"/>	<input type="checkbox"/>	Ear infections	<input type="checkbox"/>	<input type="checkbox"/>	Cancer	<input type="checkbox"/>	<input type="checkbox"/>	Alopecia
<input type="checkbox"/>	<input type="checkbox"/>	Hay fever	<input type="checkbox"/>	<input type="checkbox"/>	Varicose veins	<input type="checkbox"/>	<input type="checkbox"/>	Numbness and tingling
<input type="checkbox"/>	<input type="checkbox"/>	Mumps	<input type="checkbox"/>	<input type="checkbox"/>	Tonsillitis	<input type="checkbox"/>	<input type="checkbox"/>	Cold hands and feet
<input type="checkbox"/>	<input type="checkbox"/>	Sinusitis	<input type="checkbox"/>	<input type="checkbox"/>	Poor memory	<input type="checkbox"/>	<input type="checkbox"/>	Fainting
<input type="checkbox"/>	<input type="checkbox"/>	Canker sores	<input type="checkbox"/>	<input type="checkbox"/>	Balance problems	<input type="checkbox"/>	<input type="checkbox"/>	Heart attack or stroke
<input type="checkbox"/>	<input type="checkbox"/>	Ringing in ears	<input type="checkbox"/>	<input type="checkbox"/>	Hepatitis	<input type="checkbox"/>	<input type="checkbox"/>	HPV or Herpes
<input type="checkbox"/>	<input type="checkbox"/>	Strep throat	<input type="checkbox"/>	<input type="checkbox"/>	Alcoholism	<input type="checkbox"/>	<input type="checkbox"/>	Visual Problems
<input type="checkbox"/>	<input type="checkbox"/>	Parasites	<input type="checkbox"/>	<input type="checkbox"/>	Depression	<input type="checkbox"/>	<input type="checkbox"/>	Anxiety
<input type="checkbox"/>	<input type="checkbox"/>	Sexual abuse	<input type="checkbox"/>	<input type="checkbox"/>	Emotional abuse	<input type="checkbox"/>	<input type="checkbox"/>	Mono

Anything else we should know about your health?

Informed Consent

We would like to take this opportunity to welcome you to Halifax Naturopathic Health Centre. This clinic utilizes the principles and practices of naturopathic medicine and other supporting therapies to assist the body's own ability to heal and to improve the quality of life and health through natural means.

Your doctor will conduct a thorough case history. A physical exam, and blood and/or urinary laboratory reports may be used as part of the treatment work-up.

Statement of Acknowledgement

As a patient of this clinic I have read the information and understand that the form of medical care is based on Naturopathic and other supportive principles and practices. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or 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 not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains, disc injuries from spinal manipulations.

I also confirm that I have the ability to accept or reject the care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

CANCELLATION POLICY

Please give 24 hour notice if you cannot make it to your appointment. In the event that 24 hour notice isn't given, a cancellation fee of the full appointment will be applied to your credit card.

Card # _____ Expiry: _____ CVD#: _____

Patient Signature: _____ Date: _____



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