Halifax Naturopathic HEALTH CENTRE

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: [ ] Single [ ] Partnered [ ] Married [ ] Separated [ ] Divorced [ ] Widowed Occupation:

Name of MD: Date of last physical exam:

PERSONAL HEALTH HISTORY

Childhood illness: [ ] Measles [ ] Mumps [ ] Rubella [ ] Chickenpox [ ] Rheumatic Fever [ ] Polio

Vaccinations:

Tetanus [ ]	Pneumonia [ ]
Hepatitis [ ]	Chickenpox [ ]
Influenza [ ]	MMR Measles, Mumps, Rubella [ ]

Please list your primary health concerns or reason for visit:

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 ☐ No ☐				
	Describe your typical daily diet in the space below:				
	Breakfast				
	Lunch:				
	Dinner:				
	Snacks:				
	Drinks (juice, pop, milk, etc):				
	How many glasses of water do you drink per day?				
Digestion	Do you experience? (check all that apply) ☐ Gas ☐ Bloating ☐ Constipation ☐ Diarrhea ☐ 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? ☐ Yes ☐ No			
Caffeine	None ☐	Coffee ☐	Tea ☐	Cola ☐	
	# of cups/cans per day?				
Alcohol	Do you drink alcohol? ☐ Yes ☐ No	How many drinks per week?			
Tobacco	Do you smoke? ☐ Yes ☐ No	Packs/day	Year quit?		
Drugs	Do you currently use recreational or street drugs?			☐ Yes	☐ No
Sex	Are you sexually active?			☐ Yes	☐ No
	If yes, are you trying for a pregnancy?			☐ Yes	☐ No
	If not trying for a pregnancy list contraceptive or barrier method used:				
	Any discomfort with intercourse?			☐ Yes	☐ No

FAMILY HEALTH HISTORY

	AGE	SIGNIFICANT HEALTH PROBLEMS		AGE	SIGNIFICANT HEALTH PROBLEMS
Father			Grandparent	M ☐ F ☐	
Mother			Grandparent	M ☐ F ☐	
Siblings	M ☐ F ☐		Siblings	M ☐ F ☐	

MENTAL HEALTH

Do you often feel stressed?	☐ Yes	☐ No
Do you feel depressed?	☐ Yes	☐ No
Are you overwhelmed by stress?	☐ Yes	☐ No
Does stress affect your sleep?	☐ Yes	☐ 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?	☐ Yes	☐ No
Have you had a D&C, hysterectomy, or Cesarean?	☐ Yes	☐ No
Any urinary tract, or yeast infections within the last year?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Any problems with control of urination?	☐ Yes	☐ No
Any hot flashes or sweating at night? When did this start?	☐ Yes	☐ No
Do you have menstrual tension, pain, bloating, irritability, or other symptoms at or around time of period?	☐ Yes	☐ No
Experienced any recent breast tenderness, lumps, or nipple discharge?	☐ Yes	☐ No
Have you had a pap and breast exam within the last year?	☐ Yes	☐ No

ASSIGNED MALE AT BIRTH

Do you usually get up to urinate during the night?	☐ Yes	☐ No
If yes, # of times _____		
Do you feel pain or burning with urination?	☐ Yes	☐ No
Any blood in your urine?	☐ Yes	☐ No
Do you feel burning discharge from penis?	☐ Yes	☐ No
Has the force of your urination decreased?	☐ Yes	☐ No
Have you had any kidney, bladder, or prostate infections within the last 12 months?	☐ Yes	☐ No
Do you have any problems emptying your bladder completely?	☐ Yes	☐ No
Any difficulty with erection or ejaculation?	☐ Yes	☐ No
Any testicle pain or swelling?	☐ Yes	☐ No
Have you had a recent prostate and rectal exam?	☐ Yes	☐ 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
☐	☐	Allergies	☐	☐	Gallstones	☐	☐	Epilepsy
☐	☐	Asthma	☐	☐	Arthritis (including gout)	☐	☐	Migraines
☐	☐	Eczema	☐	☐	Thyroid problems	☐	☐	Headaches (tension/cluster)
☐	☐	Psoriasis	☐	☐	Anemia	☐	☐	Diabetes
☐	☐	Acne	☐	☐	High blood pressure	☐	☐	Pneumonia
☐	☐	Ear infections	☐	☐	Cancer	☐	☐	Alopecia
☐	☐	Hay fever	☐	☐	Varicose veins	☐	☐	Numbness and tingling
☐	☐	Mumps	☐	☐	Tonsillitis	☐	☐	Cold hands and feet
☐	☐	Sinusitis	☐	☐	Poor memory	☐	☐	Fainting
☐	☐	Canker sores	☐	☐	Balance problems	☐	☐	Heart attack or stroke
☐	☐	Ringing in ears	☐	☐	Hepatitis	☐	☐	HPV or Herpes
☐	☐	Strep throat	☐	☐	Alcoholism	☐	☐	Visual Problems
☐	☐	Parasites	☐	☐	Depression	☐	☐	Anxiety
☐	☐	Sexual abuse	☐	☐	Emotional abuse	☐	☐	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-exiting 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 cancallation fee of the full appointment will be applied to your credit card. If a credit card has not been provided, you will be invoiced for the missed appointment. The invoice will be due and payable immediately and additional appointments will require advance payment.

Card # _____ Expiry: _____ CVD#: _____

Patient Signature: _____ Date: _____

Halifax Naturopathic Health Centre

6243 Almon St
Halifax, NS B3L 1V1
T. 902.407.0808
F. 902.407.0809
www.halifaxnaturopathic.ca