Halifax Naturopathic Health Centre – Initial Adult Questionnaire

Please fill in the following intake form to the best of your ability prior to your appointment.

Name:	**DOB (dd/mm/yyyy):**	**Gender:**	**Sex:**
Address:	**City:**	**Province:**	**Postal code:**
Phone:	**Alt phone:**	**Email:**	
Emergency contact:	**Relationship:**	**Phone:**	
Where did you hear about us?			

Personal health information:

Family doctor name:	**Address:**	**Phone:**

Please list your health concerns/reason for your visit:

What are your goals and expectations through this consult?

Health history

Current height:	**Current weight:**	
Are you pregnant?	☐ Yes	☐ No
Are you breastfeeding?	☐ Yes	☐ No
Are you trying to conceive?	☐ Yes	☐ No

Please list any surgical procedures you have undergone

Date	Procedure	Result/complications

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Please check the conditions you have or have had in the past. Please add any additional conditions not found in this table in the comments box at the end of this section.

Now	Past	Condition	Now	Past	Condition	Now	Past	Condition
☐	☐	Acne	☐	☐	Alcoholism	☐	☐	Allergies
☐	☐	Anemia	☐	☐	Angina/heart attack	☐	☐	Anxiety
☐	☐	Appendicitis	☐	☐	Arthritis	☐	☐	Asthma
☐	☐	Autoimmune	☐	☐	Cancer	☐	☐	Candida
☐	☐	Celia disease	☐	☐	Cervical dysplasia	☐	☐	Chicken pox
☐	☐	Chronic bronchitis	☐	☐	Chronic fatigue	☐	☐	Colitis/Crohn's
☐	☐	Depression	☐	☐	Diabetes	☐	☐	Digestive issues
☐	☐	Diphtheria	☐	☐	Drug abuse	☐	☐	Easy bruising/bleeding
☐	☐	Ectopic pregnancy	☐	☐	Eczema	☐	☐	Emphysema/COPD
☐	☐	Endometriosis	☐	☐	Enlarged prostate	☐	☐	Epilepsy
☐	☐	Fibromyalgia	☐	☐	Food sensitivities	☐	☐	Gall stones
☐	☐	German measles	☐	☐	Gonorrhea	☐	☐	Gout
☐	☐	Head injury	☐	☐	Headaches/migraine	☐	☐	Heart disease
☐	☐	Heart murmur	☐	☐	Hemorrhoids	☐	☐	Hepatitis
☐	☐	High blood pressure	☐	☐	High cholesterol	☐	☐	HIV
☐	☐	Hives	☐	☐	HPV	☐	☐	Hyperthyroid
☐	☐	Hypothyroid	☐	☐	Intestinal polyps	☐	☐	Irregular menses
☐	☐	Kidney disease	☐	☐	Kidney stones	☐	☐	Liver disease
☐	☐	Low blood pressure	☐	☐	Lupus	☐	☐	Lyme disease
☐	☐	Measles	☐	☐	Memory loss	☐	☐	Meningitis
☐	☐	Mental illness	☐	☐	Miscarriage	☐	☐	Mononucleosis
☐	☐	Multiple sclerosis	☐	☐	Mumps	☐	☐	Nasal polyps
☐	☐	Nerve damage	☐	☐	Osteoporosis	☐	☐	Overweight
☐	☐	Parasites	☐	☐	Pelvic inflammatory disease	☐	☐	Peritonitis
☐	☐	Pleurisy	☐	☐	Pneumonia	☐	☐	Polio
☐	☐	Polycystic ovaries	☐	☐	Psoriasis	☐	☐	Rheumatic fever
☐	☐	Rheumatism	☐	☐	Roseola	☐	☐	Rubella
☐	☐	Scarlet fever	☐	☐	Seizures	☐	☐	Sickle cell anemia
☐	☐	Strep throat	☐	☐	Stroke	☐	☐	Syphilis
☐	☐	Tuberculosis	☐	☐	Ulcers	☐	☐	Varicose veins
☐	☐	Whooping cough						

Details on above conditions or any additional conditions not listed above:

Medications and supplements

Please list any vitamins, herbs or supplements you are currenting using:

Name	Dosage	Recommended by	Reason for use

Please list any prescription or over the counter medications you are currenting using:

Name	Dosage	Recommended by	Reason for use

Comments/additional space:

Family medical history

Please list any medical conditions in your immediate family

☐ Family medical history unknown

Relative	Medical conditions
Mother	
Father	
Brother	
Sister	
Maternal grandparents	
Paternal grandparents	

Is there anything else we should be aware of?

Allergies and sensitivities

Please list any allergies, sensitivities, or intolerances you are aware of:

Allergy/sensitivity	Reaction

Declaration and consent to treatment

Your naturopathic 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 understand that this form of healthcare is based on naturopathic principles and practices. I confirm that 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. I recognize that therapies can potentially have complications. 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; adverse reactions to natural health products; 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 hours notice isn't given, a cancellation fee of the full appointment will be applied to your credit card.

I acknowledge that I have been informed of, and fully understand the above ☐ Yes ☐ No

Date: _____

Name: _____

Signature: _____