Qualicum Naturopathic Clinic
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Patient Intake Form

Please take time to fill out the following form. It provides a basis for further questions during your visit and helps properly assess your situation. All information is for office use only and will be kept confidential.

General:

Date of visit: ____________________

Full Name: ___________________________________

Place of Birth: City/Town: _________________ Prov: _________ Country: _________

Date of Birth: _____________mm/dd/yyyy Age: _____ Gender: ___________

Current Address: ____ City: _______________

Postal Code: __________ Tel. No.: Home: ________________ Work: ____________________

Email Address: ____

Occupation: ____________________________ Full-time or Part-time? _______

Extended Healthcare Insurance Co. (If applicable): ____________________$____________________
Company Name Maximum Annual Coverage

Emergency Contact and relationship to patient: ____

Tel. No.: ___________________

How did you find out about the naturopathic services at this clinic?
☐ Newspaper ☐ Word of Mouth ☐ Yellow Pages \ Canpages ☐ Radio ☐ Other (please specify):

____

Last physician or health care practitioner seen and when? ____________________________________
____

When was your last blood test and what was it for? ______________________________________

____ Blood type: _______________

Health Concerns:

What are your chief health concerns? (In order of importance to you) ______________________________
1) ____
2) ____
3) ____

General state of health: ☐ poor ☐ fair ☐good ☐ very good ☐ excellent
Comments: ____
____
____
____
____

Indicate which of the following you have or may have had:

☐ Abscess
☐ Abortion
☐ Alcoholism
☐ Anemia
☐ Arthritis
☐ Asthma
☐ Cancer
☐ Chicken pox
☐ Cold sores
☐ Depression
☐ Diabetes
☐ Eczema
☐ Emphysema
☐ Epilepsy
☐ Fibrocystic Breast Disease
☐ Frequent colds
☐ Gout
☐ Gallstones
☐ Genital herpes
☐ Genital warts
☐ Gonorrhea
☐ Hay fever
☐ Headaches
☐ Heart disease
☐ HIV
☐ Influenza
☐ Kidney disease
☐ Leukemia
☐ low/high blood pressure
☐ Malaria
☐ Measles
☐ Menstrual cramps
☐ Miscarriage
☐ Mono
☐ Multiple Sclerosis
☐ Mumps
☐ Parasites
☐ Peritonitis
☐ Pelvic inflammatory disease
☐ Pleurisy
☐ Pneumonia
☐ Prostatitis
☐ PMS
☐ Psoriasis
☐ Rheumatic fever
☐ Rubella
☐ Scarlet fever
☐ Skin diseases
☐ Sinusitis
☐ Stroke

Others: ____
____
____

List any accidents, injuries, and hospitalizations (including type and year of occurrence): _____________
____

List any known allergies (including food, drugs, herbs, environmental, etc.):

Typical diet (usual daily intake as well as any dietary restrictions):
Breakfast:
Lunch:
Supper:

List daily intake of supplements (vitamins, minerals, herbs, etc.):

Are you currently working with a medical doctor (MD)? ☐ Yes ☐ No
State diagnosis given by MD (if applicable):

List any medical treatments you are undergoing and/or medications you are currently using (if applicable), including dosage and duration of use:

Please indicate if you have worked or are currently working with other practitioners (e.g. chiropractor, physiotherapist, professional counsellor, psychologist, social worker, etc.). If in the past, please state when and duration of treatment:

Screening tests (include year of test and results):

Immunizations (include date and if experienced any adverse effects from them):

How is your:

Sleep (include usual time of sleep and wake, daytime naps, and any difficulties in falling asleep or staying asleep):

Energy (best and worst time of day):____
Mood: ____
Appetite: ____
Menses (Menstruation):____
Bowel function: ____

Do you exercise? ☐ Yes ☐ No
If yes, include type, frequency and duration: _____________________________________
____
____

Indicate whether you have been or are exposed/use the following (and if so, how much):
☐ Tobacco smoke ____
☐ Coffee ____
☐ Tea ____
☐ Pop ____
☐ Alcohol ____
☐ Recreational drugs ____
☐ Excess stress ____
☐ Chemicals ____

What is your:

Current Weight: ______ Max. Weight: _______ Min. Weight: _______ Height: _______

Has your weight changed in the last 12 months? ☐ Yes ☐ No

If so, by how many pounds? Lost: _____________ Gained: _____________

What do you feel is your weakest organ system and why? ______________________________
____
____

Indicate below any health conditions that have afflicted members of your family:

Relative	**Age if alive**	**Age at death**	**Health condition(s)**
Mother:			
Father:			
Brothers:			
Sisters:			
Children:			
Maternal Grandmother:			
Maternal Grandfather:			
Maternal Aunts/Uncles:			
Paternal Grandmother:			
Paternal Grandfather:			
Paternal Aunts/Uncles:			

Describe your family/work relationships: e.g. – (Stressful vs. Peaceful; Fulfilling)

____
____
____
____
____
____

List important events/experiences in your life

____
____
____
____
____
____
____

What is a typical day like for you?

____
____
____
____
____
____

How long have you had your current health problems?

____
____

How long do you think it will take for you to heal? ____________________________________

How much effort are you willing to put into your health? 1 2 3 4 5 6 7 8 9 10 (10= maximum effort)

Please rate from 1 – 10 (10= max) how important each of these things are in your life?

Career___, Money___, Health___, Romance___, Fun & Recreation___, Personal Growth___, Family & Friends___, Physical Environment___

Thank you for taking the time to fill out this form.