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Patient Intake Form

(please print clearly)

Patient's Full Name:_____ Date:_____

Patient's Date of Birth:_____ Sex: Male / Female
Day / Month / Year (Circle One)

Full Address:_____
Street # Street Name Unit# City Province Postal Code

Telephone:_____ _____
Home (include area code) Work/Cell (include area code & extension) or email

May we leave messages relating to your visits? **Y** **N**

Occupation:_____

Chief Complaint:_____
Acute or Chronic?
(Circle one)

In Case of Emergency:
Contact:_____ Relation:_____ Tel.:_____

Referral to Clinic:_____
(Who? Where? Publication?)

Other health care providers:

Name			
Clinic			
Phone			

What are your other health concerns, in order of importance to you:

_____
_____
_____
_____
_____

Medical history:

How would you describe your general state of health (Circle)? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations (along with approximate dates).

_____

_____

Do you have any allergies (to foods, medicines, environmental, etc.)? Please explain:

_____

_____

Please list all current medications:

Prescription Drugs	Over-The-Counter Drugs	Supplements (vitamins, etc)	Herbal medicines	Homeopathic medicines

Please list past prescription medications:

_____

_____

_____

How many times have you taken antibiotics? _____ In the past year? _____

Do you frequently use any of the following? (Please Circle)

Aspirin Laxatives Antacids Diet pills Birth control pill/injection

Alcohol (how much/day or week) _____

Tobacco (form and amount/day) _____

Caffeine (form and amount/day) _____

Recreational drugs (what and how often) _____

Please circle what immunizations you have had:

DPT (diphtheria, pertussis, tetanus) Tetanus booster (when?): _____

MMR (measles, mumps, rubella) "Flu" Haemophilus influenza B Polio

Hepatitis A Hepatitis B Smallpox other: _____

Any adverse reactions to immunizations: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.) **Y** **N**

Diet:

Do you have any food allergies or intolerances? Please list.

_____
_____
_____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc)?

_____
_____

Describe a typical day's diet:

Breakfast: _____
Lunch : _____
Dinner: _____
Snacks: _____

How frequently do you consume a serving of the following food groups? (Circle day or week)

Meats (beef, pork, chicken): _____ times per day / week
Milk, cheese, ice cream, cottage cheese, yoghurt: _____times per day / week
Eggs: _____times per day / week Fruits: _____ times per day / week
Wheat (pasta, bread, pastries, etc.):_____times per day / week
Other grains (rice, oats, barley, millet, rye): _____times per day / week
Raw/Uncooked Vegetables (salads, carrots, etc.): _____ times per day / week
Cooked vegetables (frozen vegetables, potatoes, etc.): _____ times per day / week
Juices: _____ times per day / week What type of juice? _____
Nuts (peanuts, almonds, cashews, walnuts, etc.): _____ times per day / week

Family medical history:

Indicate if a close relative (parent, child, sibling) has had any of the following:

Condition	Who?	Condition	Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug/alcohol abuse	
High blood pressure		Kidney disease	
Cancer		Diabetes	
Autoimmune disease		Other	

☐ I don't know my family medical history.

Environment:

Hobbies: _____

How often do you get exercise? _____per week / per month
What do you do for exercise?

_____

_____

Are you exposed to significant tobacco smoke (work, home, socially)? Y N

Are you frequently exposed to animals (work, pets, etc)? Y N

How is your home heated?: _____

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe:_____

_____

_____

How would you describe the emotional climate of your home?

_____

_____

Please rate the level of stress at your work, or in other aspects of your life (scale: 1-10): _____
Please describe the nature of your stress:

_____

_____

How well do you handle these stresses?

_____

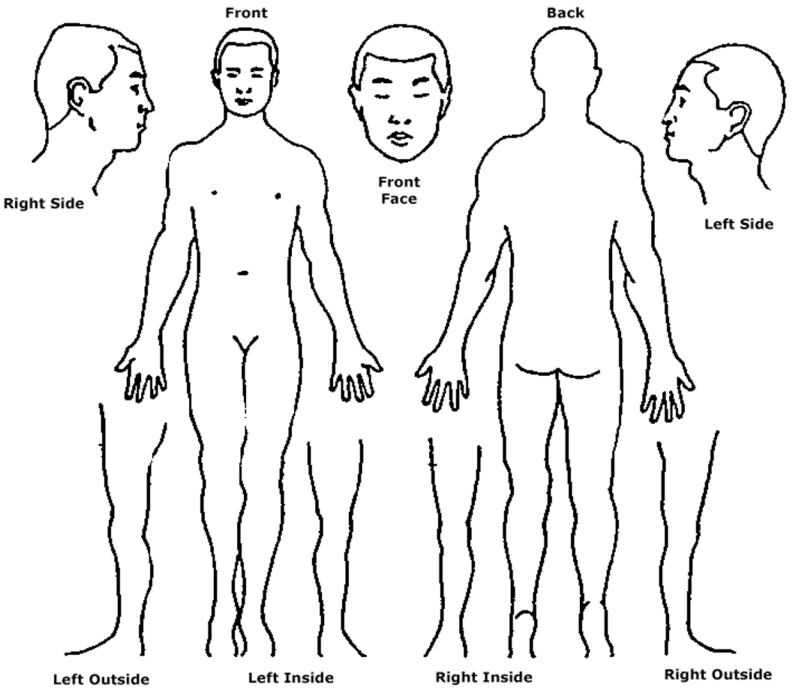
Is there anything that you feel is important that has not been covered?

_____

_____

If applicable, indicate any painful or distressed areas:

Symbol	Reaction	Symbol	Reaction
Pain on Pressure		**Spontaneous Pain**	
X	Slight	+	Slight
XX	Moderate	++	Moderate
XXX	Strong	+++	Strong
Swelling		**Pulsing**	
⊗	Slight	•	Slight
⊗⊗	Moderate	••	Moderate
⊗⊗⊗	Strong	•••	Strong
Tension/Weakness		**Temperature**	
W	Weak	⇓	Colder
	Normal		Normal
T	Tense	⇑	Hotter
O	Sores	#	Rash



Informed Consent

Dr. Reina Persaud, B.Sc., N.D.
Doctor of Naturopathic Medicine

I hereby request and consent to the diagnostic and therapeutic procedures required for my health treatment by the Doctor of Naturopathic Medicine as named above. I, the undersigned, will rely on the Doctor to exercise judgment during the course of assessment and treatment, according to my best interests and the facts then known. I understand that my health records will be kept confidential, and not released to others unless so directed by myself or my representative, or unless it is required by law.

I further understand and am informed that, as in all health care, in the practice of Naturopathic Medicine, there are some very slight risks to treatment. These include, but are not limited to:

- Aggravation of pre-existing symptoms as in a healing crisis
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from venipuncture or acupuncture
- Muscle strains, sprains or disc injuries from spinal manipulation

I do not expect the doctor to be able to anticipate and explain all risks and complications and wish to rely on the Doctor to exercise her best judgement during the course of the procedures.

I have been informed of the nature and purpose of Naturopathic treatments, the financial costs, expected benefits, potential risks and side effects, the likely consequences of not having/following the procedures, and alternative courses of action available to me.

I have read the above consent and have also had an opportunity to ask questions about its content. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures required for my health treatment. I intend this consent form to cover the entire course of diagnosis and treatment for my condition.

I understand that the medical practitioner endeavours to provide the best possible diagnosis and course of treatment. However, many factors will be important in determining actual results. Therefore, no representation or warranty is made with respect to any treatment, action or application of medical advice or information given.

Patient Name (please print): _____

Signature of Patient (or Guardian): _____

Date: _____