Happy Family Wellness Clinic

25 -10815 Bathurst St.
Richmond Hill, ON L4C 9Y2
Tel.: 905-737-5559 Fax: 905-737-5556

NATUROPATHIC INTAKE FORM

Date: _____/_____/_____

Last name:_____ First name: _____ Middle name:_____

Date of birth: _____/_____/_____ Sex: M F Height: _____ Weight: _____

Address: _____ City: _____

Province: _____ Postal Code: _____-_____ Email: _____

Daytime Phone number: (_____) _____-_____ Evening time Phone number: (_____) _____-_____

Emergency contact: _____ Relationship: _____

Name of present MD: _____ Phone (_____) _____-_____

Date of last medical doctor visit:_____ Date of last physical exam:_____

Do you get regular screening tests done by another doctor (Pap, blood tests, etc.)? **Yes / No**

How did you hear about us? _____

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

1. _____
2. _____
3. _____
4. _____
5. _____

If you are female, are you currently pregnant? **Yes / No**

Medical Health of Patient:

Please check item(s) which **apply today or did in the past**:

☐ Asthma	☐ Constipation	☐ Anxiety / Depression
☐ Diabetes	☐ Diarrhea	☐ Headaches
☐ Arthritis	☐ Allergies	☐ Heartburn
☐ Cancer _____	☐ High Cholesterol	☐ Other _____

Happy Family Wellness Clinic

Past Childhood Illnesses:

☐ Asthma ☐ Chicken pox ☐ Whooping cough ☐ Measles

☐ Rheumatic fever ☐ Polio ☐ Mumps ☐ Tuberculosis

☐ Rubella(German measles) ☐ Scarlet fever ☐ Roseola ☐ Other_____

Vaccinations: Please note vaccination in **BOLD** are considered routine as per the Ontario Childhood Immunization Schedule 2004

☐ **DPT (Diptheria, Pertussis, Tetanus)** ☐ BCG (Tuberculiosis) ☐ **Pneumococcal Conjugate**

☐ **MMR (measles, mumps, rubella)** ☐ Hepatitis A **(Meningitis/pneumonia)**

☐ Gardasi/Cervarix (HPV Vaccine) ☐ **Hepatitis B** ☐ **Meningococcal C**

☐ Haemophilus Influenza B ☐ Flu Vaccine **Conjugate (Meningitis)**

☐ Varivaz/Varilrix (Chicken Pox) ☐ **Polio** ☐ Other_____

Any reactions to the vaccines, and if so, what kind? _____

Current Medications and Nutritional Supplements:

Any antibiotics? **Y / N** total number of courses of antibiotics: _____

1- Medication: _____ For: _____ Start Date:_____

Length of time on drug: _____ Reactions to drug? _____

2- Medication: _____ For: _____ Start Date: _____

Length of time on drug: _____ Reactions to drug? _____

3- Medication: _____ For: _____ Start Date: _____

Length of time on drug: _____ Reactions to drug? _____

Supplements (vitamins, minerals, herbs, etc.): _____

Do you frequently use any of the following?

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills ☐ Birth control/injections/implants

☐ Alcohol – how many drinks/week? _____

☐ Tobacco – Amount/day? _____How many years? _____ Type?_____

☐ Caffeine – cups of coffee/tea per day? _____

☐ Recreational drugs – what and how often _____

Past hospitalizations: _____

Past surgeries: _____

Happy Family Wellness Clinic

Family Medical History:

Please indicate by noting **M** (mother), **F** (father), **S** (sibling), **PGM** (paternal grandmother), **MGM** (maternal grandmother), **PGF** (paternal grand father), **MGF** (maternal grandfather)

Allergy, asthma or eczema _____ Liver disease _____ Cancer _____
Arthritis _____ Diabetes or low blood sugar _____ Mental illness _____
Heart disease _____ Lung disease _____ High blood pressure/stroke _____
Kidney disease _____ Other: _____

Diet and Lifestyle Habits:

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 _____
Beverages (and total quantity) _____

Occupation _____Hobbies _____

Do you have trouble sleeping or falling asleep? **Y / N**
Explain: _____

Do you exercise? **Y / N** If yes, how many hours per week? _____

How old is the home? _____ How is it heated? _____

Is it located near: ☐trees ☐powerlines ☐highways ☐industry ☐other: _____

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

_____

How is the emotional atmosphere at home?

_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

_____

Happy Family Wellness Clinic

General Review of Systems:

Do you have any rashes, lumps, sores, itching, dry skin, change in hair or nails? **Y / N**

If yes: _____

Have you ever been unconscious, had a convulsion, have recurring headaches or had a head injury? **Y / N**

If yes: _____

Any problems with hearing, ringing in the ears, dizziness, ear infections, discharge? **Y / N**

If yes: _____

Any problems with teeth, gums, tongue, sore throats or hoarseness? **Y / N**

If yes: _____

Any problem with the eyes, including vision? **Y / N**

If yes: _____

Have you ever had a cough, wheeze, or asthma? **Y / N**

If yes: _____

Any recurring problem with vomiting, diarrhea, constipation or stomach pain? **Y / N**

If yes: _____

Any unusual problem on passing urine or any unusual frequency? Any unusual smell or appearance to the urine? **Y / N**
If yes: _____

Do you complain of any extremity or lower back pain? **Y / N**

If yes: _____

Have you ever had blackouts, seizures, weakness, paralysis, numbness or loss of sensation, tremors, or other involuntary movements? **Y / N**

If yes: _____

Do you have any thyroid trouble, excessive thirst or hunger, heat or cold intolerance, or diabetes? **Y / N**

If yes: _____

Any allergies, eczema, hay fever, hives or drug reactions? **Y / N**

If yes: _____

Do you have any intense fears, mood swings, or other sensitivities? **Y / N**

If yes: _____

OTHER HEALTH CONCERNS & ADDITIONAL INFORMATION:

_____