

Naturopathic Patient Intake Energy Health Clinic

Date: _____

Name: _____

Birth Date (M/D/Y): _____ BC Care Card: _____

Home Address: _____

City: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Occupation: _____ Work Phone: _____

Email Address: _____

Do you have extended health coverage? _____

Plan Number: _____ ID Number: _____

Who referred you to our clinic? _____

List your health concerns in order of importance:

1) _____

2) _____

3) _____

4) _____

5) _____

Name and phone number of Medical Doctor: _____

Major surgeries, hospitalizations, injuries (including approximate dates)

Current medications (prescription, over the counter, supplements, herbs etc.)

Known Allergies (To medications, food, environmental, and/or chemical)

Personal Health Habits

Height: _____ ft. Current Weight: _____ lbs. Ideal Weight: _____ lbs.

Maximum Weight: _____ lbs. Year: _____

Smoker: Yes _____ No _____ Smoked for _____ yrs, # per Day _____
Year Stopped, if applicable _____

Alcohol: Yes _____ No _____ Type _____ Frequency _____

Recreational Drugs: Yes _____ No _____ Type _____ Frequency _____

Coffee Yes _____ No _____ _____ Cups per day

Tea Yes _____ No _____ _____ Cups per day

Are there any food groups you avoid? Yes _____ No _____

If "Yes", what type _____

Medical History Please check only those that pertain to YOU personally.

<input type="checkbox"/>	Alcohol abuse	<input type="checkbox"/>	Allergies
<input type="checkbox"/>	Anemia	<input type="checkbox"/>	Arthritis
<input type="checkbox"/>	Back, Muscle or Joint Pain	<input type="checkbox"/>	Bladder/Urinary Concerns
<input type="checkbox"/>	Depression	<input type="checkbox"/>	Digestive Complaints
<input type="checkbox"/>	Diabetes	<input type="checkbox"/>	Epilepsy
<input type="checkbox"/>	Fatigue	<input type="checkbox"/>	Female Gyneological Concerns
<input type="checkbox"/>	Gallstones	<input type="checkbox"/>	Gum/Teeth Concerns
<input type="checkbox"/>	Heart Attack	<input type="checkbox"/>	Heart/Cardiovascular Concerns
<input type="checkbox"/>	High Blood Pressure	<input type="checkbox"/>	Kidney Concerns
<input type="checkbox"/>	Liver concerns	<input type="checkbox"/>	Lung concerns
<input type="checkbox"/>	Weight concerns	<input type="checkbox"/>	Skin concerns
<input type="checkbox"/>	STIs	<input type="checkbox"/>	Stroke
<input type="checkbox"/>	Thoughts of suicide	<input type="checkbox"/>	Sexual dysfunction
<input type="checkbox"/>	Ulcers	<input type="checkbox"/>	Thyroid condition
<input type="checkbox"/>	Other infections	<input type="checkbox"/>	Other

Additional Information

Please list any additional topics that you feel are important we discuss during your visit
