Kelowna Naturopathic Clinic Inc.
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PATIENT INTAKE FORM

Identifying Data

Name: _____
Age:_____ Date of Birth: _____
Sex: M or F Marital Status:_____
Nationality / Race: _____
Number of Children:_____
Occupation:_____
Home Address: _____
City:_____

Province:_____ Postal Code: _____
Telephone # (home):_____
(work): _____
e-mail address: _____
Emergency Contact: _____
Telephone #: _____
Family M.D.:_____
Referred by:_____

I am aware that all tests, procedures and prescriptions are my responsibility and must be paid for at the time services are rendered.

Signed: _____ Witnessed: _____ Date: _____

Major Health Concerns (in order of priority)

1) _____
2) _____
3) _____
4) _____

Were there any significant events that preceded the beginning of your chief concern? (eg. accident, illness, surgery, stress, etc.)_____

Other practitioners you are currently seeing or have recently seen and treatments you are receiving.

	Name	Type of Practitioner	Treatment
1)			
2)			
3)			
4)			

Family Medical History: Please list the current age and all relevant medical problems. If deceased, list age and cause of death.

Mother: _____
Father: _____
Brothers:_____
Sisters: _____
Spouse: _____

Children: _____
Any Familial diseases?: _____

Which childhood diseases have you had? chicken pox mumps measles whooping cough rheumatic or scarlet fever diphtheria polio other _____

As an infant were you breast fed?: yes or no For how long? _____ (months)
Immunizations**:** complete or partial Adverse reactions _____

Past surgeries: (circle and date)

tonsils _____	appendix _____	gallbladder_____	hysterectomy_____
hernia _____	tubal ligation _____	vasectomy_____	prostate_____
minor surgery _____	back_____	varicose veins _____	skin lesions _____
cosmetic _____	other_____		

Past Hospitalizations: (date, reason & length of stay) _____
_____
_____
_____

Past Medical Illness: (date & describe all major illnesses) _____
_____
_____
_____
_____

Dental History: (circle and date)
silver amalgams/crowns _____gold amalgams / crowns_____dental implants _____
wisdom teeth removed _____root canals_____dental appliances/bridges/dentures _____
What condition are your teeth and gums in? _____

Allergies and Drug Reactions: list and describe the reaction.
Drug: _____
Food: _____
Chemical: _____
Pollens/Molds: _____
Insects/Animals: _____

Current Medication: List all prescription, over the counter, health food store, multi-level marketed drugs, supplements, herbs etc.. you take regularly.
_____
_____
_____

Menstrual History:
Age of onset _____Date of last period _____Date of last PAP smear_____
Was it normal? _____# of days between periods _____Duration of bleeding_____
Amount of blood loss _____P.M.S. or cramps?_____Is your period regular? _____
List any past menstrual or gynecological problems _____

Difficulty conceiving?_____# of pregnancies _____# of deliveries _____
Any birth complications? _____# of cesarean sections _____# of miscarriages_____
# of abortions _____# of D & Cs _____Age at menopause_____
Menopausal symptoms _____

PERSONAL PROFILE / SOCIAL HISTORY

Dietary Habits: - Briefly list what you eat and drink at a typical meal.
Breakfast: _____
Lunch:_____
Supper: _____
Snacks: _____

How do you rate your diet? excellent good average poor terrible
Do you follow a specific diet? yes or no What kind?_____
Amount of water drank daily?_____ What type? tap bottled home filtered
Do you smoke? yes or no How much per day? _____Type _____
Recreational drug use: yes or no Type _____ How much or often? _____
Is this a concern for you? yes or no
Alcohol use: daily several times per week weekends only occasional rarely never
Alcoholic beverage of choice _____ Amount consumed per use _____

Employment History: How many hours per day do you work? _____ Please briefly list all major jobs / occupations in the past. _____
_____
_____

Education History: What is the highest level of education you've completed? _____

Travel History: Have you been out of the country recently? yes or no When? _____
For how long?_____ Where? _____
Are any of your health problems related to your travels? yes or no

Marital History: Any major problems with your marriage? yes or no Any past divorces? yes or no
How many?_____ Are you sexually active? yes or no Any sexual related concerns? yes or no
Please briefly describe _____

General Health:
Do you exercise regularly? yes or no Type(s) _____
How often? _____ For how long?_____ Do you sleep well? yes or no
hours per night_____ Do you sleep through the night? yes or no
How long to fall asleep? _____ Do you awaken feeling rested? yes or no
Any financial difficulties? yes or no Recent or long term?_____
Pets at home? yes or no How many? _____ What kind?_____
For how long? _____ Where do they sleep? _____
Do you regularly relax, meditate or pray? yes or no What do you do for stress management? _____
_____
Age of the home that you live in? _____ Is dust or mold a problem in your house? yes or no
Has there been any recent renovations done to your home in the last 3 years? yes or no
Do you like your home and where you live? yes or no

REVIEW OF SYSTEMS

Please circle Y - a condition you have now. P - a condition you have had in the past, but is okay now.
N - a condition you have never had. Record significant details in the margins.

Present weight _____ (lbs.)
Maximum weight _____ (lbs.) When? _____
Desired weight _____ (lbs.) Height _____

General Body
fatigue ..... Y P N
fever ..... Y P N
chills ..... Y P N
night sweats ..... Y P N

Skin
eczema / rash ..... Y P N
psoriasis ..... Y P N
acne, boils ..... Y P N
hives ..... Y P N
peculiar moles ..... Y P N
lumps ..... Y P N
bruising ..... Y P N
pigmentation change ..... Y P N
itch ..... Y P N

Hair
abnormal loss ..... Y P N
change in texture ..... Y P N

Nails
brittle ..... Y P N
ridging ..... Y P N
pitting ..... Y P N
abnormal curvature ..... Y P N
not growing ..... Y P N

Head
stress headache ..... Y P N
migraine headache ..... Y P N
head injury ..... Y P N
head pain ..... Y P N

Eyes
impaired vision ..... Y P N
cataracts ..... Y P N
glaucoma ..... Y P N
eye pain ..... Y P N
discharge ..... Y P N
tearing ..... Y P N
dryness ..... Y P N
redness ..... Y P N
burning / itching ..... Y P N
light sensitivity ..... Y P N
blindness ..... Y P N
glasses or contacts ..... Y P N

Ears
impaired hearing ..... Y P N
ringing ..... Y P N
dizziness ..... Y P N
recurrent infections ..... Y P N
discharge ..... Y P N

Nose / Sinuses
impaired smell ..... Y P N
nose bleeds ..... Y P N
nasal / sinus congestion ..... Y P N
runny nose ..... Y P N
recurrent infection ..... Y P N
post nasal drip ..... Y P N
hayfever ..... Y P N

Mouth / Throat
impaired taste ..... Y P N
recurrent sore throat / infection ..... Y P N
gum disease ..... Y P N
sore tongue ..... Y P N
hoarseness / laryngitis ..... Y P N
bad breathe ..... Y P N
canker sores ..... Y P N

Respiratory
chronic cough ..... Y P N
shortness of breathe ..... Y P N
wheezing ..... Y P N
blood in sputum ..... Y P N
chest pain ..... Y P N
recurrent pneumonia / bronchitis ..... Y P N
asthma ..... Y P N
emphysema ..... Y P N
tuberculosis ..... Y P N

Cardiovascular
high blood pressure ..... Y P N
murmurs, arrhythmia ..... Y P N
angina ..... Y P N
valve disease ..... Y P N
palpitations ..... Y P N
cold extremities ..... Y P N
varicose veins / phlebitis ..... Y P N
swelling in ankles ..... Y P N
strokes / heart attacks ..... Y P N

Please circle Y - a condition you have now. P - a condition you have had in the past, but is okay now.
N - a condition you have never had. Record significant details in the margins.

Gastro-intestinal

change in appetite ..... Y P N
impaired swallowing ..... Y P N
heartburn / indigestion ..... Y P N
gas ..... Y P N
bloating ..... Y P N
abdominal pain ..... Y P N
nausea ..... Y P N
vomiting ..... Y P N
B.M.. / day .....
blood in stool ..... Y P N
constipation ..... Y P N
diarrhea ..... Y P N
liver disease / jaundice ..... Y P N
gallbladder disease ..... Y P N
ulcers ..... Y P N
irritable bowel syndrome ..... Y P N
hemorrhoids ..... Y P N

Urinary

pain on urination ..... Y P N
increased frequency ..... Y P N
awakening at night to urinate ..... Y P N
urinary urgency ..... Y P N
blood in urine ..... Y P N
flank pain ..... Y P N
recurrent bladder, kidney infection ..... Y P N
kidney stones ..... Y P N
incontinence ..... Y P N

Male Reproductive

pelvic pain ..... Y P N
impotence ..... Y P N
premature ejaculation ..... Y P N
testicular masses ..... Y P N
testicular pain ..... Y P N
hernias ..... Y P N
prostate disease ..... Y P N
breast enlargement or pain ..... Y P N
sexually transmitted disease ..... Y P N
discharge or sores ..... Y P N
what do you use for birth control? .....

Female Reproductive

pelvic pain ..... Y P N
post intercourse bleeding ..... Y P N
post menopausal bleeding ..... Y P N
sexually transmitted disease ..... Y P N
discharge or sores ..... Y P N
what do you use for birth control? .....

Breasts

do you self examine? ..... Y P N
lumps ..... Y P N
cysts ..... Y P N
pain or tenderness ..... Y P N
nipple discharge ..... Y P N

Musculoskeletal

joint swelling / inflammation ..... Y P N
joint pain / stiffness ..... Y P N
arthritis ..... Y P N
impaired range of motion ..... Y P N
weakness ..... Y P N
muscle cramps ..... Y P N
bone fractures ..... Y P N
disc disease ..... Y P N

Neurological

seizures ..... Y P N
fainting spells ..... Y P N
tremor ..... Y P N
paralysis ..... Y P N
numbness / tingling ..... Y P N
loss of memory ..... Y P N
weakness ..... Y P N
balance problems ..... Y P N
speech difficulties ..... Y P N

Blood / Lymphatic

anemia ..... Y P N
leukemia ..... Y P N
bruising / bleeding easily ..... Y P N
lymph gland swelling ..... Y P N
transfusions ..... Y P N

Endocrine / Hormonal

heat / cold intolerance ..... Y P N
excessive thirst / hunger ..... Y P N
thyroid problems / goiter ..... Y P N
diabetes ..... Y P N
excessive facial hair (female) ..... Y P N

Immune

frequent colds / infections ..... Y P N
allergic disorders (e.g.) hayfever ..... Y P N
asthma, eczema, hives, etc.. ..... Y P N
do odors bother you? ..... Y P N

Please circle Y - a condition you have now. P - a condition you have had in the past, but is okay now.
N - a condition you have never had. Record significant details in the margins.

Psychological

psychiatric problems or hospitalization.....Y P N
anxiety.....Y P N
depression.....Y P N
drug or alcohol abuse .....Y P N
mood swings .....Y P N
violence potential.....Y P N
obsessive / compulsive.....Y P N
phobias .....Y P N
"stressed out" .....Y P N

Additional medical history not included elsewhere that you feel is relevant.

NOTE:THIS IS A CONFIDENTIAL RECORD OF YOUR MEDICAL HISTORY AND WILL BE KEPT IN THIS OFFICE.
Information contained here will not be released to any person except when you have authorized us to do.