

Phone: 250-868-2205  
Fax: 250-868-2099

**Dr. Garrett G. Swetlikoff, N.D.**  
160-1855 Kirschner Road  
Kelowna, B.C., V1Y 4N7

website: [www.natural-medicine.ca](http://www.natural-medicine.ca)  
e-mail: [info@natural-medicine.ca](mailto:info@natural-medicine.ca)

### 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.: \_\_\_\_\_  
 PHN: \_\_\_\_\_

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