



CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

ROBERT SCHAD NATUROPATHIC CLINIC

Adult Intake

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Name _____ Date _____

Date of birth _____ (M/D/Y) Preferred Pronoun He She Other _____

Address: _____ Apt/unit # _____

City _____ Province _____ Postal Code _____

E-mail Address: _____

Telephone number: Home: _____ Work: _____ Cell: _____

May we leave messages relating to your visits? Which Phone Number _____

Emergency contact: Name: _____

Phone number(s):_(_____) _____ or_(_____) _____ Relation: _____

How did you hear about our Clinic? Please check one of the following:

- | | |
|---|--|
| <input type="checkbox"/> A patient of the clinic (please provide name)
_____ | <input type="checkbox"/> Social Media (Facebook, Twitter etc.) |
| <input type="checkbox"/> My medical doctor/Specialist (please provide name) _____ | <input type="checkbox"/> CCNM Website |
| <input type="checkbox"/> Other Health Care Provider (please provide name): _____ | <input type="checkbox"/> CCNM Student, staff or faculty |
| <input type="checkbox"/> Advertising (newspaper, TTC, brochure) | <input type="checkbox"/> Information Session |
| | <input type="checkbox"/> External Sports Medicine event |
| | <input type="checkbox"/> CCNM E-Newsletter |
| | <input type="checkbox"/> Other: _____ |

How would you identify your gender?

Women Man Non binary Prefer to self-disclose _____

Other health care providers you are seeing:

Name: _____ Name: _____ Name: _____

Specialty: _____ Specialty: _____ Specialty: _____

Ph (_____) _____ Ph (_____) _____ Ph (_____) _____

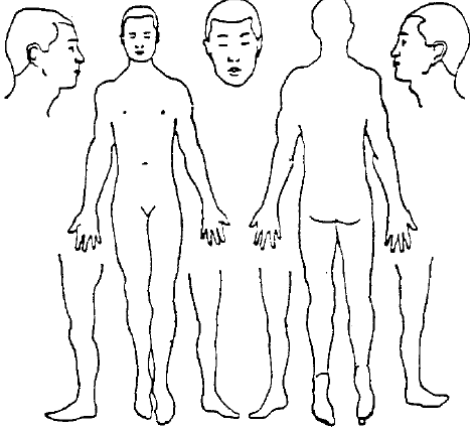
Date of last visit: _____ Date of last visit: _____ Date of last visit: _____

Have you ever consulted (Please check all that apply):

Naturopathic doctor Acupuncturist Nutritionist Counselor

Health Goals

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

Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?	Indicate Painful or distressed areas:
1.		
2.		
3.		
4.		
5.		

Are you currently pregnant? Yes No Due date _____

Are you currently lactating? Yes No

Medical history

How would you describe your general state of health?

Excellent Good Fair Poor

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

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Do you have any allergies (medicines, environmental, etc.)?

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

- | | | |
|----------|----------|----------|
| 1) _____ | 3) _____ | 5) _____ |
| 2) _____ | 4) _____ | 6) _____ |

Please list past prescription medications/natural health products:

Please indicate Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers: _____
 Laxatives: _____ Antacids: _____ Diet pills: _____
 Birth control: _____
 Antibiotics: _____
 Alcohol—how much/day or week _____
 Tobacco—form and amount/day _____
 Caffeine—form and amount/day _____
 Recreational drugs—what and how often _____

Please indicate what immunizations you have had:

DPT (diphtheria, pertussis, tetanus) Haemophilus influenza B Hepatitis A
 Tetanus booster; when? "Flu" Hepatitis B

 MMR (measles, mumps, rubella) Polio Smallpox
 Other _____

Please indicate if any caused adverse reactions: _____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Yes No
 Last time you had blood work done _____

Personal and Family History

Please place a "Y" in the "yes" box next to each condition that applies to you and/or one of your family members. Please indicate all who the condition applies to: "Self" if it relates to you and/or Father (F), mother (M), sibling (S), Grandparent (G), your child (C). Please indicate **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes	Relation	Past or Current Condition		Yes	Relation	Past or Current Condition
Alcoholism/Drug addiction				High Blood pressure			
Allergies				Heart Disease			
Anemia				Hepatitis			
Arthritis				Headaches			
Asthma				Kidney disease			
Cancer				Stroke			
Diabetes				Tuberculosis			
Eczema				Osteoporosis			
Epilepsy				Others:			
Depression/other Mental Illness							

I don't know my family medical history

Diet

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

- | | |
|----------|----------|
| 1) _____ | 4) _____ |
| 2) _____ | 5) _____ |
| 3) _____ | 6) _____ |

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

Environment

Occupation _____

Hobbies _____

Do you exercise regularly? What do you do for exercise, how much, how often?

Are you exposed to significant tobacco smoke (work, home, etc.)?

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

How is your home heated? _____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? _____

How would you describe the emotional climate of your home?

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

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

