Centre for Natural Medicine Inc
403 542 3763 Dr. Angela Kirk, BSc, ND **www.naturally.ca**

PATIENT INTAKE FORM - ADULT

Name: _____
Mailing Address: _____
_____
Telephone (h): _____ (w): _____ Email: _____
Date of Birth: _____ Age: _____ Male [ ] Female [ ]

Family/Home Status: (single, live with friends, married, single parent, etc.)
_____
Height: _____ Weight: _____ Blood Type: _____
Family Doctor: _____ phone: _____
Chiropractor: _____ phone: _____

Other Health Care Provider (please specify what treatment they provide):
_____
_____
Past Naturopathic Doctor: _____
Emergency Contact Person: _____
Relation: _____ Phone (home): _____ (work): _____
Known Diseases: _____
Known Allergies: _____

Please state why you have chosen Naturopathic Medicine: _____
_____
_____

Chief Health Concerns (In order of importance):
1. _____
2. _____
3. _____
4. _____
5. _____

Detailed history of your primary health concern (onset, pertinent dates and procedures if any): _____
_____
_____
_____

Referred to us by: _____

Can you trace the origin of the present illness to any particular circumstance, accident, illness, incident, mental upset, or unusual stress in your life? Explain. _____
_____
_____
_____

In regards to your chief complaint, please list what treatments, regimes, diets, and therapies, if any, have brought real improvement or relief?
_____
_____

Which have brought no improvement or relief? _____
_____

Do you use any of the following?

☐ COFFEE OR BLACK TEA | AMOUNT: _____
☐ TOBACCO | # DAILY: _____
☐ SODA POP/ CARBONATED BEVERAGE | AMOUNT: _____
☐ LIQUOR / BEER / WINE | AMOUNT: _____
☐ ALKISELSER/ TUMS/ ETC. | AMOUNT: _____
☐ MARGARINE TYPE: _____
☐ PROCESSED FOODS TYPE: _____
☐ RECREATIONAL DRUGS TYPE: _____
☐ LAXATIVES TYPE: _____
☐ ASPARTAME # PRODUCTS | DAILY: _____

Do you exercise? (Include type, frequency, duration, and intensity):
_____
_____

Do you have a problem with addiction: yes [ ] no [ ]
Type: Food [ ] Alcohol [ ] Drugs [ ] Other: _____
Hours a day you spend: Working: _____Sleeping: _____ Watching TV: _____
Recreation (not TV):_____ Doing something you love: _____

What is your STRESS LEVEL (10 = High Stress)
1 2 3 4 5 6 7 8 9 10

What is your main stressor? _____
How would you describe your daily mood and energy?_____
_____

List all the Food Supplements, Health Products, and Prescription Drugs you are currently taking. Use the other side of this sheet if needed.

Product	Dosage	Why	Since	When

Have you had any of your organs surgically removed? Which one(s)?

_____

List any significant traumas you have lived through. (Car accident, injuries, surgery, divorce, death of a loved one, …)

_____

What was your childhood like? _____

_____

Please list your offspring and their ages:
Children: _____ Grandchildren: _____

Context of Care

What 3 expectations do you have from your first visit?
1) _____
2) _____
3) _____

What long-term expectations do you have from working with our clinic?

_____

_____

What expectations do you have of me personally, as your physician?

_____

_____

Thank you for providing me with this information.
I look forward to serving you in the best ways I am able.

Cancellation Policy

Please ensure to give 2 business days cancellation notice. For appointments cancelled on the same day, full cost of the appointment will be charged. For those cancelled with only 1 business days notice, 50% of the appointment fee will be charged. Consideration will be given to unforeseeable circumstances, at the discretion of the Centre for Natural Medicine.

Please sign that you have read and agree to the cancellation policy as written above:

Signature: _____ Date: _____