PICKERING WELLNESS CENTRE

From Pain Relief to Wellness Care Naturally!!
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Naturopathic Intake – ADULT (Please print clearly)

Let's begin your journey towards health. As a Naturopathic Doctor, I believe that effective healthcare is only possible when the health care provider has a complete understanding of the patient on a physical, mental and emotional level. Please take the time to fill out the following form. It provides me with information to properly assess your case and health. All information is for office use only and will be kept confidential.

Today's Date: ___________________

PATIENT INFORMATION:

Name:____
(First) (Middle) (Last)
Age: ______________ DOB (M/D/Y): _________________ Sex (M/F): _______________________________
Marital Status: ______________________________
Children: Y/N If yes, please indicate how many and age? ____
Occupation: _______________________________
Height: ___________________________ Weight: ____
How did you hear about Nisha Patel, ND? ____
Extended Healthcare Insurance Company (if applicable):
____

CONTACT INFORMATION:

Home Address: ____
City: ____________________ Province: ___________________ Postal Code: ______________________________
Home Phone: ____________________________ Cell Phone: ____
Work Phone: ____
May we leave messages at the above phone numbers? Y/N
If so, which phone number? ____
Email address: ____

EMERGENCY CONTACT INFORMATION:
Name: ____
Relationship: ____
Phone Number: ____
Alternative Phone Number: ____
Email Address: ____

OTHER HEALTH CARE PROVIDERS YOU ARE SEEING:

1) Name: ____
Phone Number: _________________________________
Location: ______________________________________
Date of Last Visit: ______________________________
Specialty: _____________________________________

2) Name: ____
Phone Number: _________________________________
Location: ______________________________________
Date of Last Visit: ______________________________
Specialty: _____________________________________

3) Name: ____
Phone Number: _________________________________
Location: ______________________________________
Date of Last Visit: ______________________________
Specialty: _____________________________________

HEALTH CONCERNS:
Please list your primary health concerns in order of importance:
1) ____________________
2) ____________________
3) ____________________
4) ____________________
5) ____________________

Do you have any known contagious disease at this time? Y/N
If yes, what? ____________________

Please list any diagnosis you have received in the past and present, who diagnosed the condition and the relevant dates:
____
____

Are you currently pregnant: Y/N If yes, indicate due date: ____________________
Are you currently lactating? Y/N

MEDICAL HISTORY:
How would you describe your general state of health? Please circle one
Excellent Good Fair Poor

Please list any serious conditions, illnesses, injuries, and any hospitalizations below, along with their approximate dates: ____________________
____
____

Do you have any allergies/sensitivities? If so, what to?
____
____

Please list all prescription medications, over the counter medications, vitamins or other supplements you are currently taking with dosages and frequency:
1) ____________________
2) ____________________
3) ____________________
4) ____________________
5) ____________________

Please list all past prescription medications, over the counter medications, vitamins or other supplements you have taken: ____________________
____

Do you frequently take any of the following products? (Please circle all that apply)
Aspirin Tylenol Ibuprofen Laxatives Antacids
Diet Pill Birth control pills Cough remedies Antibiotics

Please indicate what immunizations you have had (DPT, MMR, Haemophilus influenza B, Tetanus, Flu, Hepatitis A, Hepatitis B, Polio, Small pox etc.):
____
____
____

Please indicate if any caused adverse reactions:
____

PERSONAL HEALTH HABITS:
Do you or have you ever smoke? ____
If so, how many packs per day? ____
How long have you or did you smoke? ____

Do you or have you ever consumed alcohol? ____
How many drinks do you drink per week on average? _____________________________________

How much caffeine do you consume per week? ____

Do you use recreational drugs? If so, what type and how often? ___________________________

Do you exercise? ____
If yes, include type, frequency and duration? ____
____

Please describe your typical daily diet, including beverages:
Breakfast: ____
Lunch: ____
Dinner: ____
Snacks: ____

FAMILY HISTORY:
Indicate which of your close relatives suffers from any of the following conditions: (mother, father, grandmother, grandfather, sibling, child)

Alcoholism/Drug Addiction:	Allergies:	Anemia:
Arthritis:	Asthma:	Cancer:
Diabetes:	Eczema:	Epilepsy:
Depression/Other Mental Illness:	High Blood Pressure:	Heart Disease:
Hepatitis:	Headaches:	Kidney Disease:
Stroke:	Tuberculosis:	Osteoporosis:
Liver Disease:	Female Reproductive Problems:	Male Reproductive Problems:
Thyroid Problems:	Autoimmune Disease:	Others:

ENVIRONMENTAL FACTORS:
What is your occupation? ____
What are your hobbies? ____
____
Are you exposed to significant tobacco smoke (work, home, etc.)? Y/N

Are you frequently exposed to animals (work, pets, etc.)? Y/N
How is your home heated? ____

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 cope with these stresses?
____
____
____

Is there any additional important information you would like to provide?
____
____
____
____

Thank you for taking the time to fill out this form.
Please return to front desk/reception.

____ ________________________

Patient Signature Date