Naturopathic Medicine and Registered Acupuncture

Adult New Patient Intake Form

Please fill this form out entirely and bring it with you to your first office visit.

This form is meant to gather as much information as possible. Please fill it out to the best of your knowledge. If there are areas you cannot or would not like to answer, please leave that area blank.

Today's Date: _____

Contact Information

Full Name _____
Address _____ City _____
Province _____ Postal Code_____
Telephone: best number to reach you on _____ Other_____
Email Address_____
Would you like to receive our quarterly email newsletter? Yes / No
Date of Birth (mm/dd/yyyy)_____Age _____ Gender: Male / Female
Marital Status_____
Occupation _____Number of hours worked per week _____

Name of Medical Doctor_____
Telephone ( )_____Fax (____)_____
Are you currently under his/her care? Yes / No
If yes, for what condition(s)?_____
Date of last physical_____
How or by whom were you referred to this clinic?_____

Have been treated by a Naturopathic Doctor or Registered Acupuncturist before? Yes / No
If yes, by whom?_____ When?_____

In case of Emergency:

Contact (full name)_____
Relationship to you_____
Telephone Number_____

Current Health

What are your primary health concerns? List as many as you can, in the order of their importance to you. (attach a separate sheet if necessary)
1) _____
2) _____
3) _____
4) _____
5) _____

Check all that apply to you or your immediate family (parents, siblings, grandparents).

- ○ Asthma
- ○ Cancer
- ○ Cardiac Disease
- ○ Diabetes
- ○ History of back pain
- ○ Hypertension
- ○ Psychiatric Disorders
- ○ Seizure Disorder
- ○ Stroke

Check all symptoms you are currently experiencing.

- ○ Allergy
- ○ Cardiovascular
- ○ Chest Pain
- ○ Connective Tissue
- ○ Diabetes
- ○ Ear/Nose/Throat
- ○ Eye
- ○ Fever
- ○ Digestive Concerns
- ○ Bladder Concerns
- ○ Hematological (blood)
- ○ Swelling Concerns
- ○ Muscle/Joint Concerns
- ○ Neurological
- ○ Mood Changes
- ○ Respiratory
- ○ Skin Concerns
- ○ Weight Gain/Loss

Please list, by name, all **current** prescription medications, over-the-counter medications, and all vitamins/supplements/herbs you take regularly at this time. Include dose, brand name and approximate date you began. ***Note: Please bring each of these with you to your first visit.***

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____
8) _____
9) _____
10) _____

Please list any medication allergies: _____

Please check all that are true:

- ○ current / history of tobacco use
- ○ at risk for falls or falling injuries
- ○ current / history of illegal drug use
- ○ currently pregnant

Please describe your alcohol consumption?

- ○ Daily
- ○ Weekly
- ○ Monthly
- ○ Occasionally
- ○ Rarely
- ○ Never

Do you regularly get screening tests done by a health care professional? Yes / No
Which ones? (Please check)

- ○ Blood tests
- ○ Bone density scan (DEXA)
- ○ Mammogram
- ○ Pap
- ○ Digital Rectal Exam (Prostate exam)
- ○ Fecal occult blood
- ○ Other _____

Height: _____Weight: _____History of significant weight loss or gain? Yes / No

Rate your energy level during the day from 1 to 5 (1 being worst, 5 being best).

Morning: _____ Afternoon: _____
Lunch: _____ Evening: _____

List your primary interests and hobbies:

_____
_____
_____
_____

List your primary form of exercise, if any, and how often.

_____
_____
_____
_____

Medical History

Please list any serious illnesses, injuries, hospitalizations, surgeries and conditions along with dates.

1) _____
2) _____
3) _____
4) _____
5) _____
6) _____
7) _____

Please list past medications

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

Please indicate which immunizations you have had (Please check)

- ○ DPT (diphtheria/pertussis/tetanus)
- ○ MMR (measles, mumps, rubella)
- ○ Chicken pox (Varicella/Varivax)
- ○ Tetanus booster
- ○ Flu vaccine
- ○ Hepatitis B
- ○ Hepatitis A
- ○ Polio
- ○ Haemophilus influenza B
- ○ Shingles (Herpes Zoster)
- ○ HPV (Gardasil)
- ○ Other – please list_____
- ○ Not immunized

Have you ever had an adverse reaction to an immunization? Yes / No

Dr. Lisa Vecchi, ND, RAc
Dr. Michelle Peters, ND
The Massage Clinic Health Centres
7-575 River Glen Blvd, Oakville, ON
905-257-5888

Nutrition

Do you have any dietary restrictions (e.g. vegetarian, religious, ethical, etc.)? Please describe.

_____
_____

Please indicate which of the following are true. Check all that apply.

- ○ Eat 3 meals or more per day
- ○ Drink tea
- ○ Drink coffee
- ○ Drink soft drinks
- ○ Add sugar/salt to food
- ○ Go on diets more than once yearly
- ○ Use products with artificial sweeteners
- ○ Eat out more than twice a week

Please give a typical day's diet (24 hours) – remember to be honest, it's the only way to find the problems!

Breakfast: _____
Snack: _____
Lunch: _____
Snack: _____
Dinner: _____
Snack: _____
Amount of Water: _____

Lifestyle

Please indicate which of the following are true (please check).

- □ Get 6-8 hours of sleep per night
- □ Sleep well
- □ Awake feeling rested
- □ In a supportive relationship
- □ History of abuse
- □ Suffered major life trauma
- □ Enjoy your work
- □ Take vacations
  How often?_____
- □ Spend time outside
- □ Watch TV -Hours daily?____
- □ Read - Hours daily?_____

Do you have any other concerns that have not been covered?

_____
_____
_____
_____
_____

_____ _____
Signature Date (mm/dd/yyyy)