MARINE DRIVE
NATUROPATHIC CLINIC

101-1277 Marine Drive Naturopathic Clinic, North Vancouver BC V7P 1T3 (604) 929-5772

"Get your life back, not your symptoms" ™

Successful health care and preventative medicine are possible when the physician has a complete understanding of the patient physically, mentally and emotionally. Please complete this questionnaire as thoroughly as possible. If you have any questions, mark them with a question mark. Thank you!

CONFIDENTIAL Patient Intake Form

Date: _____Name: _____

Address: _____ City: _____ Postal Code: _____

Home #: _____ Work #: _____Cell #: _____

Date of birth (D/M/Y) _____ Age: _____ Sex: M / F Marital Status_____ Occupation: _____

Person to Contact in Emergency:

Name _____ Relationship _____ Telephone: _____

How did you hear about us? _____

Email Address: (for email appointment reminders) _____

Would you like to receive clinic newsletters/information via email? Yes No

Names of Other Healthcare Providers:

MD (Medical Doctor) _____ND (Naturopathic Doctor) _____

Chiropractor/ Acupuncturist _____Other _____

PHN (Care Card Number) _____

List your main health concerns in order of importance:

1. _____ 4. _____

2. _____ 5. _____

3. _____ 6. _____

Personal Health Information

Height_____Weight_____Weight 1Yr ago _____Blood type _____ Smoker: YES/NO

Alcoholic drinks per week: _____ Recreational drugs: YES/NO Caffeinated drinks per day: _____

Current stress level:___/10 Energy Level: ____/10 Hours of exercise per week: _____ Hours of sleep per night: _____

Dental health: _____Allergies: _____

Are you currently taking any medications? If so please list them here.

_____

Past Medical History - Please circle and date (year) if any of these apply to you:

Cancer	Diabetes	Hepatitis	Seizures	Heart Disease	Rheumatic Fever	Thyroid Disease	Venereal Disease

Other _____

Surgeries_____

Significant Trauma (auto accidents, falls, etc.) _____

Your Birth (Prolonged labor, forceps delivery, etc.) _____

Family History - Please circle if any of these apply to you or your family:

Cancer	Diabetes	Heart Disease	High Blood Pressure	Anemia	Kidney Disease
Seizures	Asthma/Hay Fever	Tuberculosis	Depression	Schizophrenia	Dementia
Arthritis					

Other_____

Review of Systems - Check any symptoms that are current or recurring concerns

General:

- ☐ Poor appetite
- ☐ Change of appetite
- ☐ Tremors
- ☐ Bleed/bruise easily
- ☐ Weight loss
- ☐ Fatigue
- ☐ Strong Thirst
- ☐ Night sweats
- ☐ Sudden energy
- ☐ Localized weakness
- ☐ Poor balance
- ☐ Cravings
- ☐ Chills
- ☐ Fever
- ☐ Sweat Easily
- ☐ Poor sleep

Skin & Hair:

- ☐ Weight gain
- ☐ Hives
- ☐ Loss of hair
- ☐ Ulcerations
- ☐ Itching
- ☐ Eczema
- ☐ Pimples
- ☐ Rashes
- ☐ Recent Moles
- ☐ Dandruff

Any other hair and skin problems?_____

Head, Eyes, Ears, Nose & Throat:

- ☐ Dizziness
- ☐ Headaches
- ☐ Concussions
- ☐ Migraines
- ☐ Facial pain
- ☐ Earaches
- ☐ Ringing in ears
- ☐ Poor hearing
- ☐ Copious saliva
- ☐ Sore lips/tongue
- ☐ Sore throats
- ☐ Cavities
- ☐ Grinding teeth
- ☐ Teeth problems
- ☐ Swollen glands
- ☐ Jaw clicks
- ☐ Eye pain
- ☐ Glasses/contacts
- ☐ Poor vision
- ☐ Cataracts
- ☐ Night blindness
- ☐ Color blindness
- ☐ Spots in front of eyes
- ☐ Blurry vision
- ☐ Eye strain
- ☐ Sinus problems
- ☐ Nose bleeds
- ☐ Loss of smell

Any other head or neck problems? _____

Cardiovascular:

- ☐ High blood pressure
- ☐ Palpitations
- ☐ Rheumatic fever
- ☐ Low blood pressure
- ☐ Dizziness
- ☐ Murmurs
- ☐ Chest pain
- ☐ Swelling of hands
- ☐ Blood clots
- ☐ Swelling of feet
- ☐ Fainting
- ☐ Phlebitis
- ☐ Irregular heart beat
- ☐ Cold hands and feet
- ☐ Difficulty breathing

Any other heart or blood vessel problems?_____

Respiratory:

- ☐ Cough
- ☐ Wheezing
- ☐ Production of phlegm
- ☐ Coughing blood
- ☐ Asthma
- ☐ pneumonia
- ☐ Bronchitis
- ☐ Shortness of breath at night
- ☐ Pleurisy

Any other lung problems? _____

Gastrointestinal:

- ☐ Nausea
- ☐ Vomiting
- ☐ Constipation
- ☐ Belching
- ☐ Abdominal pain
- ☐ Gas
- ☐ Black in stools
- ☐ Bad breath
- ☐ Rectal pain
- ☐ Ulcer
- ☐ Indigestion
- ☐ Chronic laxative use

☐ Liver disease ☐ Haemorrhoids ☐ Gall bladder disease ☐ Diarrhea

Bowel movements: how often?_____ Is this a change? Y/N

Any other problems with your digestion? _____

Genito-urinary:

☐ Pain on urination ☐ Frequent urination ☐ Blood in urine
☐ Urgency to urinate ☐ Unable to hold urine ☐ Kidney stones
☐ Decrease in flow

Do you wake to urinate (how often)?_____ Colour/odour of urine? _____

Any other problems with your urinary system? _____

Male:

☐ Hernias ☐ Prostate disease ☐ Testicular masses
☐ Testicular pain ☐ Herpes ☐ Discharge or sores
☐ Impotency ☐ STD (type)

Do you practice birth control? What type and for how long? _____

Any other problem with your reproductive system? _____

Female:

☐ Heavy Menses ☐ Pain on intercourse ☐ Irregular periods
☐ Abnormal pap ☐ Painful periods ☐ Bleeding in between periods
☐ Ovarian cysts ☐ Endometriosis ☐ Vaginal sores
☐ Abnormal menses ☐ Vaginal discharge ☐ Light menses
☐ Self-breast exam ☐ Clots ☐ STD (type)
☐ Breast lumps ☐ Nipple discharge ☐ Sex difficulties
☐ Menopausal symptoms ☐ Mood swings

Age of first menses_____ Date of last menses_____ Length of cycle_____ Duration of menses_____

# of pregnancies____ # of births____ # of miscarriages_____ # of abortions____ birth control (type)?_____

Musculoskeletal:

☐ Neck pain ☐ Muscle pain ☐ Knee pain
☐ Shoulder pain ☐ Back pain ☐ Muscle weakness
☐ Hand/wrist pain ☐ Arthritis ☐ Foot/ankle pain
☐ Sciatica ☐ Hip pain ☐ Broken bones

Any other bone problems?_____

Neurological:

☐ Seizures ☐ Depression ☐ Tingling
☐ Loss of balance ☐ Quick temper ☐ Concussions
☐ Poor memory ☐ Anxiety ☐ Susceptible to stress
☐ Irritable ☐ Numbness ☐ Nervousness
☐ Lack of coordination

Have you ever been treated for emotional problems? _____

Have you ever considered or attempted suicide? _____

Any other neurological or psychological problems? _____

CONSENT FORM

Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, cranio-sacral therapy, clinical nutritional, lifestyle counselling, and intravenous nutritional therapy.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side-effects. I also understand that there is no guarantee or warranty for a specific cure result.

I understand the visit costs for Naturopathic treatment are as follows:

- Initial Adult Consultation $185.00 (1 hour)
- Initial Student/ Senior (65+) Consultation $160.00
- Subsequent Adult Consultation $85.00 (30 minutes)
- Subsequent Student/ Senior Consultation $75.00

I also understand that if I miss an appointment or cancel on short notice (less than 24 hours) I may be charged a fee for the missed appointment.

Signature x_____ Date _____

Doctor's Signature x_____ Date _____

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x_____ Date _____

PREMIUM ASSISTANCE ELIGIBILITY (if applicable)

Individuals who may be eligible for premium assistance via Medical Services Plan need to include their Personal Health Number ensure accurate billing.

Care Card #_____

Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your answers will help us decipher what is going on so we can come up with the steps that will lead you to vibrant health!