



# 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      Rheumatic      Thyroid      Venereal  
Disease      Disease      Disease      Disease      Disease      Fever      Disease      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:**

- |  |   |                                       |
|--|---|---------------------------------------|
| <input type="checkbox"/> Poor appetite       | <input type="checkbox"/> Strong Thirst      | <input type="checkbox"/> Cravings     |
| <input type="checkbox"/> Change of appetite  | <input type="checkbox"/> Night sweats       | <input type="checkbox"/> Chills       |
| <input type="checkbox"/> Tremors             | <input type="checkbox"/> Sudden energy      | <input type="checkbox"/> Fever        |
| <input type="checkbox"/> Bleed/bruise easily | <input type="checkbox"/> Localized weakness | <input type="checkbox"/> Sweat Easily |
| <input type="checkbox"/> Weight loss         | <input type="checkbox"/> Poor balance       | <input type="checkbox"/> Poor sleep   |
| <input type="checkbox"/> Fatigue             |   |                                       |

**Skin & Hair:**

- |                                       |                                      |                                       |
|---------------------------------------|--------------------------------------|---------------------------------------|
| <input type="checkbox"/> Weight gain  | <input type="checkbox"/> Ulcerations | <input type="checkbox"/> Rashes       |
| <input type="checkbox"/> Hives        | <input type="checkbox"/> Itching     | <input type="checkbox"/> Recent Moles |
| <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Eczema      | <input type="checkbox"/> Dandruff     |
|                                       | <input type="checkbox"/> Pimples     |                                       |

Any other hair and skin problems? \_\_\_\_\_

**Head, Eyes, Ears, Nose & Throat:**

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

Any other head or neck problems? \_\_\_\_\_

**Cardiovascular:**

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Murmurs           | <input type="checkbox"/> Fainting             |
| <input type="checkbox"/> Palpitations        | <input type="checkbox"/> Chest pain        | <input type="checkbox"/> Phlebitis            |
| <input type="checkbox"/> Rheumatic fever     | <input type="checkbox"/> Swelling of hands | <input type="checkbox"/> Irregular heart beat |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Blood clots       | <input type="checkbox"/> Cold hands and feet  |
| <input type="checkbox"/> Dizziness           | <input type="checkbox"/> Swelling of feet  | <input type="checkbox"/> Difficulty breathing |

Any other heart or blood vessel problems? \_\_\_\_\_

**Respiratory:**

- |   |   |   |
|---|---|---|
| <input type="checkbox"/> Cough                | <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Bronchitis                   |
| <input type="checkbox"/> Wheezing             | <input type="checkbox"/> Asthma         | <input type="checkbox"/> Shortness of breath at night |
| <input type="checkbox"/> Production of phlegm | <input type="checkbox"/> pneumonia      | <input type="checkbox"/> Pleurisy                     |

Any other lung problems? \_\_\_\_\_

**Gastrointestinal:**

- |                                       |   |  |   |
|---------------------------------------|---|--|---|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Belching       | <input type="checkbox"/> Black in stools | <input type="checkbox"/> Ulcer                |
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Abdominal pain | <input type="checkbox"/> Bad breath      | <input type="checkbox"/> Indigestion          |
| <input type="checkbox"/> Constipation | <input type="checkbox"/> Gas            | <input type="checkbox"/> Rectal pain     | <input type="checkbox"/> 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 \$195.00 (1 hour)
- Initial Student/ Senior (65+) Consultation \$175.00
- Subsequent Adult Consultation \$90.00/\$155 (30-60 minutes)
- Subsequent Student/ Senior Consultation \$80.00

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!