Patient Intake Form

Name: ____ Date: ____________________
Address: ____
City: ______________________________________Postal Code: ______________
Phone: Home: _________________________ Office: ________________________
Cell#: ____
Age: _____ Birth date(Year/MM/DD)______________________Sex: M F
Occupation: ____________________________ Employer: ___________________
Emergency
Contact: _______________________________ Phone: ______________________
Name of Legal Guardian
(for person under 18) ____
Email Address: ____
OHIP # ____

How did you hear about our clinic? ______________________________________
Family Physician Name and Phone # ______________________________________
Other Health Care Providers ____

Have you ever been to a Naturopathic Physician before? Y N
Do you know what a Naturopathic Physician does? Y N

CHIEF COMPLAINTS

What is your chief complaint about your health?

____
____
____
____

Who diagnosed this condition?

Family Doctor: ________________ Specialist: ________________ Other: _________________

What other concerns would you like addressed?

____
____
____
____

How would you rate your health currently on a scale of 1 – 10 ____________________

MEDICAL HISTORY

Please list any past surgeries or hospitalizations with the approximate date for each:

____

____

____

List any medications that you have taken in the past 5 years __________________________

____

AGE ILLNESS MEDICATION

____

____

____

Any adverse reactions to medications? __________________________________

____

____

What medications are you taking now? __________________________________

____

____

What supplements and/or herbs are you taking now? ________________________

____

____

____

List the exercises you participate in? How often?

____

____

____

Allergies? Please list: ____

____

____

How were your allergies diagnosed? ____________________________________

____

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