



## 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?

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Who diagnosed this condition?

Family Doctor \_\_\_\_\_ Specialist: \_\_\_\_\_ Other: \_\_\_\_\_

What other concerns would you like addressed?

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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:

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

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AGE	ILLNESS	MEDICATION
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Any adverse reactions to medications?

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What medications are you taking now?

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What supplements and/or herbs are you taking now?

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List the exercises you participate in? How often?

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Allergies? Please list:

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How were your allergies diagnosed?

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