# Dr. Chris Ford and Dr. Darcie Pawlick – Naturopathic Physicians

Although this form may seem long, please note that completion of each section of this intake form is optional, however, it is beneficial for us to have a full history in order to gain a better understanding of your health and how it may be affected by all aspects of your life. All answers are fully confidential. If you have any questions please mark them with a question mark. Thank you.

**Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Date of birth** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ (M/D/Y) **Age**\_\_\_\_\_\_\_ **Gender**\_\_\_\_\_\_\_\_\_\_\_­­\_\_

**Address**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**City**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Prov./State**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Postal/Zip Code**\_\_\_\_\_\_\_\_\_\_\_

**E-mail Address** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Home Telephone Number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Alternate** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**May we leave messages relating to your visits? Yes**\_\_\_\_ **/ No**\_\_\_\_

**Which Phone Number?**\_\_\_\_\_\_\_\_\_\_

**Occupation­­**­­­\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Hours/week­­**\_\_\_\_\_\_\_\_\_

**Married**\_\_\_\_ **Separated**\_\_\_\_ **Divorced**\_\_\_\_ **Widowed**\_\_\_\_ **Single**\_\_\_\_ **Partnership**\_\_\_\_

**Live with: Spouse**\_\_\_\_ **Partner**\_\_\_\_ **Parents**\_\_\_\_ **Children**\_\_\_\_ **Friends**\_\_\_\_ **Alone**\_\_\_\_

**Names of Other Healthcare Providers: M.D.** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Naturopaths**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Chiropractors**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Others**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Emergency contact: Name** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Phone number** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_  **Relation**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**How did you hear about our Clinic**? **Please check one of the following:**

**Media (Newspaper, radio)** \_\_\_\_

**Health/Wellness Event**\_\_\_\_

**Website**\_\_\_\_

**Clinic patient**\_\_\_\_

**Other** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Referred by**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Please list your health concerns, in order of importance to you:**

1. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

2. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

3. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

4. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

5. \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Allergies**

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Medications**

**Current medications (prescription, over-the-counter, etc.)** -if more than five please list at bottom of intake form in the space given for the last question and/or bring with you for initial consult

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dose** | **Date Prescribed** | **Reason** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Supplements (Vitamins, minerals, herbs, etc.)**

|  |  |  |  |
| --- | --- | --- | --- |
| **Name** | **Dose** | **Date Prescribed** | **Reason** |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |
|  |  |  |  |

**Do you frequently use any of the following?**

**Aspirin**\_\_\_ **/ Tylenol**\_\_\_ **/ Laxatives**\_\_\_ **/ Antacids**\_\_\_ **/ Diet pills**\_\_\_ **/ Birth control**\_\_\_

**Review of Systems: Please check if you have experienced any of the following symptoms now (N) or in the past (P).**

**General**

|  |  |  |
| --- | --- | --- |
| **Poor sleep**\_\_\_\_  **Poor appetite**\_\_\_\_  **Chills**\_\_\_\_  **Fevers**\_\_\_\_  **Cravings**\_\_\_\_  **Neuropsychological**  **Depression**\_\_\_\_  **Mood swings**\_\_\_\_  **Poor memory**\_\_\_\_  **Seizures**\_\_\_\_  **Lack of co-ordination**\_\_\_\_  **Endocrine**  **Hypothyroid**\_\_\_\_  **Heat/cold intolerance**\_\_\_\_  **Seasonal depression**\_\_\_\_  **Immune**  **Chronic Fatigue Syndrome**\_\_\_\_  **Slow wound healing**\_\_\_\_  **Skin and Hair**  **Rashes** \_\_\_\_  **Acne**\_\_\_\_  **Hair loss**\_\_\_\_  **Ulcerations**\_\_\_\_  **Musculoskeletal**  **Joint pain/stiffness**\_\_\_\_  **Muscle cramps/spasm**\_\_\_\_  **Neck pain**\_\_\_\_  **Shoulder pain**\_\_\_\_  **Foot/ankle pain**\_\_\_\_  **Head/Eyes/Ears/Nose/Throat**  **Headaches**\_\_\_\_  **Head injuries**\_\_\_\_  **Glasses/contacts**\_\_\_\_  **Night blindness**\_\_\_\_  **Colour blindness**\_\_\_\_  **Glaucoma**\_\_\_\_  **Ringing in ears**\_\_\_\_  **Nose bleeds**\_\_\_\_  **Teeth grinding**\_\_\_\_  **Goiter**\_\_\_\_  **Jaw/TMJ problems**\_\_\_\_  **Respiratory**  **Cough**\_\_\_\_  **Asthma**\_\_\_\_  **Emphysema**\_\_\_\_  **Cardiovascular**  **High/low blood pressure**\_\_\_\_  **Fainting**\_\_\_\_  **Swollen feet**\_\_\_\_  **Murmurs**\_\_\_\_  **Peripheral Vascular**  **Anemia**\_\_\_\_  **Bleed/bruise easily**\_\_\_\_  **Gastrointestinal**  **Indigestion**\_\_\_\_  **Constipation**\_\_\_\_  **Vomiting**\_\_\_\_  **Hemorrhoids**\_\_\_\_  **Difficulty swallowing**\_\_\_\_  **Liver disease**\_\_\_\_  **Gall bladder disease**\_\_\_\_  **Genito-Urinary**  **Frequent urination**\_\_\_\_  **Wake to urinate**\_\_\_\_  **Male Only**  **Hernias**\_\_\_\_  **Impotency**\_\_\_\_  **Prostate disease**\_\_\_\_  **STI**\_\_\_\_  **Female Only**  **Age of first menses**\_\_\_\_  **Menstrual cramps**\_\_\_\_  **Irregular periods**\_\_\_\_  **Endometriosis**\_\_\_\_  **Sexual difficulties**\_\_\_\_  **STI**\_\_\_\_  **Bleeding between cycles**\_\_\_\_  **PMS**\_\_\_\_ **Number of pregnancies**\_\_\_\_  **Number of abortions**\_\_\_\_  **Menopausal symptoms**\_\_\_\_  **Breast lumps**\_\_\_\_ | **Night sweats**\_\_\_\_  **Sweat easily**\_\_\_\_  **Strong thirst**\_\_\_\_  **Weight gain**\_\_\_\_  **Weight loss**\_\_\_\_  **Anxiety/nervousness**\_\_\_\_  **Loss of balance**\_\_\_\_  **Dizziness**\_\_\_\_  **Numbness/tingling**\_\_\_\_  **Hypoglycemia**\_\_\_\_  **Diabetes**\_\_\_\_  **Swollen glands**\_\_\_\_  **Muscle weakness**\_\_\_\_  **Itching**\_\_\_\_  **Colour change**\_\_\_\_  **Dandruff**\_\_\_\_  **Broken bones**\_\_\_\_  **Weakness**\_\_\_\_  **Back pain**\_\_\_\_  **Knee pain**\_\_\_\_  **Head/Neck problems**\_\_\_\_  **Spots in vision**\_\_\_\_  **Double vision**\_\_\_\_  **Tearing/dryness**\_\_\_\_  **Earaches**\_\_\_\_  **Stuffiness**\_\_\_\_  **Loss of smell**\_\_\_\_  **Gum problems**\_\_\_\_  **Facial pain**\_\_\_\_  **Swollen glands**\_\_\_\_  **Difficult breathing**\_\_\_\_  **Pneumonia**\_\_\_\_  **Pain on breathing**\_\_\_\_  **Wheezing**\_\_\_\_  **Heart disease**\_\_\_\_  **Irregular heart beat**\_\_\_\_  **Rheumatic fever**\_\_\_\_  **Cold hands/feet**\_\_\_\_  **Palpitations**\_\_\_\_  **Deep leg/calf pain**\_\_\_\_  **Cold hands/feet**\_\_\_\_  **Gas**\_\_\_\_  **Abdominal pain/cramps**\_\_\_\_  **Chronic laxative use**\_\_\_\_  **Blood in stool**\_\_\_\_  **Black stools**\_\_\_\_  **Heartburn**\_\_\_\_  **Ulcer**\_\_\_\_  **Unable to hold urine**\_\_\_\_  **Blood in urine**\_\_\_\_  **Kidney stones**\_\_\_\_  **Testicular pain**\_\_\_\_  **Premature ejaculation**\_\_\_\_  **Discharge**\_\_\_\_  **Duration of menses**\_\_\_\_  **Heavy menses**\_\_\_\_  **Vaginal discharge**\_\_\_\_  **Ovarian cysts**\_\_\_\_  **If so, what symptoms?** \_\_\_\_\_\_\_\_  **Number if live births**\_\_\_\_  **Abnormal PAP**\_\_\_\_  **If so, what symptoms**\_\_\_\_\_\_\_\_\_  **Nipple discharge**\_\_\_\_ | **Sudden energy drop­**\_\_\_\_  **Peculiar tastes/smells**\_\_\_\_  **Fatigue**\_\_\_\_  **Change in appetite**\_\_\_\_  **Tension**\_\_\_\_  **Quick temper**\_\_\_\_  **Concussion**\_\_\_\_  **Considered suicide**\_\_\_\_  **Excess thirst**\_\_\_\_  **Excess hunger**\_\_\_\_  **Chronic infections**\_\_\_\_  **Frequent colds/flus**\_\_\_\_  **Eczema/hives**\_\_\_\_  **Lumps**\_\_\_\_  **Changing moles**\_\_\_\_  **Arthritis**\_\_\_\_  **Sciatica**\_\_\_\_  **Hand/wrist pain**\_\_\_\_  **Hip pain**\_\_\_\_  **Migraines**\_\_\_\_  **Blurry vision**\_\_\_\_  **Cataracts**\_\_\_\_  **Eye pain**\_\_\_\_  **Poor hearing**\_\_\_\_  **Sinus problems**\_\_\_\_  **Chronic sore throat**\_\_\_\_  **Dental cavities**\_\_\_\_  **Lumps**\_\_\_\_  **Pain/stiff neck**\_\_\_\_  **Bronchitis**\_\_\_\_  **Coughing of blood**\_\_\_\_  **Phlegm (colour)** \_\_\_\_  **Shortness of breath**\_\_\_\_  **Blood clots**\_\_\_\_  **Dizziness**\_\_\_\_  **Angina**\_\_\_\_  **Chest pain**\_\_\_\_  **Varicose Veins**\_\_\_\_  **Bad breath**\_\_\_\_  **Nausea**\_\_\_\_  **Rectal pain**\_\_\_\_  **Diarrhea**\_\_\_\_  **Jaundice (yellow skin)** \_\_\_\_  **Change in appetite**\_\_\_\_  **Pain on urination**\_\_\_\_  **Decrease in flow**\_\_\_\_  **Urgency to urinate**\_\_\_\_  **Herpes**\_\_\_\_  **Testicular mass**\_\_\_\_  **Length of cycle**\_\_\_\_\_\_\_\_\_  **Light menses**\_\_\_\_  **Vaginal sores**\_\_\_\_  **Cervical dysplasia**\_\_\_\_  **Herpes**\_\_\_\_  **Birth control**\_\_\_\_  **Miscarriages**\_\_\_\_ |

All fees for services and supplements are the responsibility of the patient, payable in full at the end of the appointment. Payment can be made in the form of cash, personal cheque, Interac or credit card. Please note that MSP *does not cover Naturopathic services (except those on Premium Assistance at a rate of $23 per visit).* Many extended health care plans cover Naturopathic medical services; please check the specifics of your plan. You will be supplied with the necessary receipts to submit to your insurance company.

**Important – Cancellation Policy**

**If you need to cancel or reschedule your appointment, 24 HOURS NOTICE *by phone* is required or there will be a cancellation fee incurred.** This fee is equivalent to the cost of the appointment missed. This helps cover clinic operation costs and avoids the need to increase consultation fees.

**Read and understood by:**

**Signature:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ **Date:** \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_