Dear New Patient,

Deciding to put your health, and YOU, as a priority takes courage. We will now embark on the journey towards optimizing your wellbeing.

If you are unfamiliar with Naturopathic Medicine, the basic goal is to understand the individual and the cause of his/her ailments so that the root of the concern/condition can be treated to improve his/her overall level of health and wellbeing. Regardless of your familiarity with Naturopathic Medicine, you have decided to incorporate its practices in your global health strategy and I invite all of my patients, current and future, to ask questions – it's your health!

The work we do together will be entirely collaborative and I will do my utmost to help you achieve your goals. I am here as a facilitator in your health and wellness, but of course, you will have to do some work.

I am so thrilled to go on this journey with you and look forward to learning from you and with you.

While the intake form may seem daunting because of the number of questions, but please do take the time to answer each section carefully as it will only better assist me in understanding where you have been and where you would like to go and to ensure the most effective use of your visit time. Included is a one-week diet diary that should be completed and brought to your first visit.

Colleen Hartwick ND

Please complete all pages of the intake form and include copies of any **recent bloodwork or pertinent labwork.** Forms may be returned by fax, mail or email **at least 3 days** prior to your appointment to ensure we can make the most of our initial visit**.**

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.

DR. COLLEEN HARTWICK
NATUROPATHIC PHYSICIAN

CONFIDENTIAL ADULT INTAKE FORM

Date: _________________
Name: ___________________________ Sex: F___ M___
Date of Birth: __________________ Age: _____
Address: _______________________________________
City: ____________________ Postal Code: ____________
Home Phone: (_____)_________ Cell (____)______________
Work Phone: (____)___________
Care Card Number: ______________________
Email Address: _______________________________________
Relationship status: _______________ Number of Dependants: ______
Family Physician: _____________________
Physician Phone: (____)____________
Emergency Contact: ______________ Phone: (____)___________
Relationship: ______________
How did you hear about us? _______________________________________

CURRENT HEALTH CONDITION

What health concerns/problems brought you to this office today? (Please list them in order of importance to you):

1. ____
2. ____
3 ____
4. ____
5. ____

Have any of these conditions/concerns recently changed or become worse? How so?
____
____
____
____

What are measures you have taken to date to improve your state of health?
.____
____
____
____

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.

DR. COLLEEN HARTWICK
NATUROPATHIC PHYSICIAN

Please list the most significant/stressful events in your life, starting with the most recent. Are any of these continuing to impact your life?

1. ____
2. ____
3 ____
4. ____
5. ____

PERSONAL HEALTH HABITS:

Height: ________ Current Weight: ________ Max. weight: _______

Weight one year ago: __________

Last Complete Physical Exam ________________________________

Smoker (check one): Current ____ Former ____ Never ____

How many years? _________ Amount/day: ____

Year stopped: ________

Are you exposed to second hand smoke?

Do you consume artificial sweeteners (aspartame, sucralose etc.)? _____

Alcohol Use: Yes Type: ______________

Frequency (servings/week)____________

Recreational Drug Use (e.g. cannabis, cocaine, ecstasy, heroin etc.

Type: ____________________ Frequency:____________________

Caffeine (coffee, black/green tea, cola, energy drinks):

Source: _________ ___ Frequency (cups/day)___________

Water intake: _______ cups/day

Type: Distilled ____ Tap water _____ Spring Water _____

Juice: ___________________________ Amount (cups/day): ________

Herbal Tea: _________ Amount (cups/day): _________

Type(s): ____

Soft Drinks (other than cola): Amount (cups/day): ________

Diet:

Any foods that you avoid?:

Which ones? ____

____

Why? ____

____

Are there any food groups that you tend to eat a lot of?

Yes ___ No _____

Which ones? ____

____

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.

Are there specific foods that you crave? When do you crave them?
____
____

Do you consume dairy products?
Which ones? ____
How often? ____

Are you or have you ever been a vegan or vegetarian? _______________
For how long? _______________________________

STRESS

How would you rate your current, average level of STRESS? (circle one)

None Some Moderate Considerable

Your main sources of stress are? (check all that apply)

- ○ Financial
- ○ Family
- ○ Health
- ○ Marriage
- ○ Interpersonal
- ○ Unfulfilled expectations
- ○ Spiritual
- ○ Job-related

I cope with stress by: ____
____

ENERGY

On a scale of 1 to 10 (10 being the most), please rate your average level of energy: _______
My energy is best: ____
My energy is worst: ____
MY energy is affected by: ____

SLEEP

How many hours of sleep do you get a night? _________
Do you wake up feeling rested? Yes ___ No ___ Occasionally ___
Do you do shift work?___________

Do you exercise regularly?: Yes ___ No ___
Type: ______________________________
Duration: _______(mins) Frequency: _____ (days/week)

Are you routinely exposed to animals? Which ones?
____

Are you regularly exposed to any hazards/toxins? Which ones?
____

Women:

Are you currently pregnant? Yes ____ No ___ Not Sure ___
Method(s) of Birth Control Used (e.g. condoms, cervical cap, diaphragm, oral contraceptive, IUD): ____

What kind/brand of oral contraceptive do you use?
____
At what age did you start? _________
Any adverse effects? ______________________

REVIEW OF SYSTEMS

Please indicate (circle) if you have experienced any of these symptoms in the Past (P) or Currently (C).

SKIN		EYES		NOSE	
Acne/Boils	C P	Cataracts	C P	Discharge	C P
Psoriasis	C P	Glaucoma	C P	Polyps	C P
Eczema	C P	Pain	C P	Itching	C P
Change in mole	C P	Redness	C P	Sinus infection	C P
Night sweats	C P	Blurred vision	C P	Post-nasal drip	C P
Colour/texture change	C P	Changes in vision	C P	Frequent colds	C P
Thinning hair	C P	Floaters	C P	Nose bleeds	C P
Temperature changes	C P	Double vision	C P	Hay fever/allergies	C P
Excessive sweating	C P	Light sensitivity	C P	Stuffiness	C P
Lumps	C P	Corrective lenses	C P		
Easy bruising/slow healing	C P	Discharge/tearing	C P	**THROAT/ MOUTH**	
Nail changes	C P	Blind spot(s)	C P	Sore throat	C P
Itching	C P			Difficulty swallowing	C P
Rash	C P			Cavities	C P
		EARS		Changes in taste	C P
		Discharge	C P	Bad breath	C P
NECK		Changes in hearing	C P	Sore tongue	C P
Enlarged lymph nodes	C P	Earaches	C P	Gingivitis	C P
Lumps	C P	Tinnitus/ringing in ears	C P	Sores/cankers	C P
Pain/stiffness	C P	Ear infection	C P	Hoarseness	C P
Goiter/enlarged thyroid	C P			Dry mouth	C P

DR. COLLEEN HARTWICK
NATUROPATHIC PHYSICIAN

ENDOCRINE		MALE REPRODUCTIVE		RESPIRATORY	
Diabetes	C P	Pain in testicles	C P	Cough	C P
Excessive thirst	C P	Regular testicular self-exam	C P	Yellow/green phlegm	C P
Excessive hunger	C P	Changes in scrotum	C P	Wheezing	C P
Excessive sweating	C P	Discharge	C P	Asthma	C P
Fatigue	C P	Sores	C P	Coughing/spitting up blood	C P
Low blood sugar	C P	STI	C P	Emphysema	C P
Heat/cold intolerance	C P	Premature ejaculation	C P	Bronchitis	C P
Unintentional weight change	C P	Impotence/low libido	C P	Tuberculosis (exposure/infection)	C P
Hormonal therapy	C P	Hernia	C P	Pain	C P
		Breast changes	C P	Shortness of breath	C P
FEMALE REPRODUCTIVE				Shortness of breath at night	C P
Menstrual cramps	C P	**MUSCULOSKELETAL**		Shortness of breath while lying down	C P
PMS	C P	Back pain	C P	Last chest X-ray	C P
Irregular periods	C P	Joint pain	C P		
Clotted menses	C P	Joint stiffness	C P	**CARDIOVASCULAR**	
Heavy flow	C P	Arthritis	C P	High blood pressure	C P
Pain with/during intercourse	C P	Broken bones	C P	Palpitations	C P
Vaginal discharge	C P	Muscle weakness	C P	Irregular heartbeat	C P
Vaginal itching	C P	Spasms/cramps	C P	Coronary artery disease	C P
Vaginal dryness	C P	Joint swelling	C P	Fatigue on exertion	C P
Sexual difficulties	C P			Murmurs	C P
Uterine fibroids	C P	**PERIPHERAL VASCULAR**		Congenital heart condition	C P
Endometriosis	C P	Varicose veins	C P	Chest pain	C P
Ovarian cysts	C P	Cold extremities	C P		
Regular Breast self-exams	C P	Swelling of hands or legs	C P	**HEAD**	
Breast tenderness	C P	Aching legs	C P	Tension headache	C P
Breast lumps	C P	Numbness of arms or legs	C P	Migraine	C P
Nipple discharge	C P	Ulcers on legs/feet	C P	Dizziness	C P
Length of menstrual cycle		Leg cramps	C P	Concussion/Trauma	C P
Length of period		Deep leg pain	C P		

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.

PSYCHOLOGICAL		GASTRO-INTESTINAL		URINARY	
Anxiety	C P	Flatulence	C P	Blood in urine	C P
Low mood	C P	Burping	C P	Cloudy urine	C P
Depression	C P	Bloating	C P	Urinary tract infection	C P
Panic attacks	C P	Diarrhea	C P	Urgency	C P
Insomnia	C P	Blood in stools/black stools	C P	Incontinence	C P
Anger/Rage	C P	Grey stools	C P	Kidney stones	C P
Mood swings	C P	Changes in bowel habits	C P	Frequency at night	C P
Phobias/fears	C P	Stomachache	C P	Difficulty urinating	C P
Nightmares	C P	Abdominal cramping	C P	Changes in frequency	C P
Drug abuse	C P	Changes in appetite	C P	Sweet-smelling urine	C P
Disordered eating	C P	Lack of appetite	C P	Urination within 10-15 minutes of drinking fluids	C P
		Nausea	C P		
		Vomiting	C P		
		Heartburn	C P		
		Sour taste in mouth	C P		
		Hemorrhoids	C P		
		Indigestion	C P		
		Ulcers	C P		
		Liver disease/hepatitis	C P		
		Gallbladder disease	C P		
		IBS/Irritable Bowel	C P		
		Celiac Disease	C P		
		Crohn's/Colitis	C P		
		Diverticular disease	C P		

PERSONAL HEALTH HISTORY:

What was the state of your mother's health when she was pregnant with you? _____________
____
How was your birth? Were there any complications? ________________________ __________
____
____
Were you breast-fed and for how long? ____________________
Did you have colic as a baby?_____________
How would you describe your health as a child until age 12? ___________________________
____
Did you have any other childhood diseases other than chicken pox, measles, or mumps? Which ones? ____

DR. COLLEEN HARTWICK
NATUROPATHIC PHYSICIAN

Please list all surgeries you have had, dates and reasons, and if you felt they were successful.

Surgery Type	Surgery Date	Reason(s) for surgery	Outcome

Have you ever had parasites? When? How were they treated?
____
____

Have you ever traveled to a developing country, if so, when and for how long?____
____

How would you characterize your level of immune function? How many times each year do you get a cold, flu or bronchitis? How many days are you sick with it? Do you miss work because of illness? ____
____

How many times have you taken antibiotics in your life? _________

Describe your bowel function (how often, size, floating/sinking, undigested food, foul odour, mucous, blood, loose/unformed/formed?
____
____

Please list all of your allergies including food and environmental.
_.____
____
____

Explain your dental health including the number of mercury amalgams you have, the number of root canals and whether you have had your wisdom teeth removed. Which teeth have been involved? _.____
____
____

Any problems ever since you have had dental work? Please explain.
____
____

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.

Has there been a trauma or sickness that you felt you have never recovered from and you have not been well since? .____
____
____

FAMILY MEDICAL HISTORY:

Please indicate if any of your blood relatives have been diagnosed with the following conditions:

Condition	Relative(s)
Asthma	
Allergies	
Anxiety	
Eating disorders	
Obesity	
High cholesterol	
High blood pressure	
Heart disease	
Thyroid disease	
Syphilis	
Tuberculosis	
Osteoporosis	
Kidney disease	
Liver disease	
Diabetes	
Bleeding disorders	
Dementia/alzheimer's	
Neuromuscular disease (e.g. Parkinson's disease, Huntington's disease, muscular dystrophy)	
Stroke	
Heart attack	
Substance abuse	
Cancer	
Other mental health disease (apart from depression and anxiety)	

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.

For any of the family members listed above, please indicate when they were deceased and what the cause of death was:

1. ____
2. ____
3. ____
4. ____
5. ____

CURRENT HEALTH PRACTICES

Have you consulted your MD regarding your chief complaints today? Some
If yes, what therapies were prescribed? __________________________________
____

Have you worked with a counselor, psychologist, or other therapist? Y
What was/were the primary reason(s) for seeking care?
.____
____
What were your results?
____
____

Before today, have you consulted a Naturopathic Doctor? N
For what reason(s)? ____
____
What treatments were used? ____
____
Was the treatment successful? ____
____

What other health care professionals are looking after your health (e.g. dentist, optometrist, acupuncturist, massage therapist, chiropractor, physiotherapist)? Please explain the reason you are receiving their care.
____
____

What **medications** are you CURRENTLY taking?

Medication Name	Dose	First prescribed?	Adverse effects noticed

Please outline any **medications** you have used in the past.

Medication Name	Reason prescribed	Effects noticed (positive or negative)

Please outline any **supplements** you are CURRENTLY taking. If you take supplements please list brands and dosages of all products you are taking and the reason for taking them.

Supplement	Brand	Reason for taking	Dosage

Yours in health,

Dr. Colleen

Dr. Colleen Hartwick ND
colleenhartwickND@gmail.com
www.campbellrivernaturopathic.com

2-1330 Dogwood St
Campbell River, BC
V9W3A6
Tel: 250-203-2317
Fax: (888)353-2779.