

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 primary goal is to understand the individual (you) and the cause of his/her/their ailments so that the root of the concern/condition can be treated to improve his/her/their 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!

I am honoured to be part of your wellness journey. 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 the work.

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.

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.

CONFIDENTIAL ADULT INTAKE FORM

Date: _____
Name: _____ Biologic sex: _____
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?

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?

Recreational Drug Use: Yes/No

Type: _____ Frequency of Use: _____

DIET:

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: _____ Amount (cups/day): _____

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

Alcohol Use: Yes/No Type(s): _____

Frequency (servings/week) _____

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? _____

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)

- | | | | |
|---------------------------------|--------------------------------|--|-----------------------------------|
| <input type="radio"/> Financial | <input type="radio"/> Health | <input type="radio"/> Interpersonal | <input type="radio"/> Spiritual |
| <input type="radio"/> Family | <input type="radio"/> Marriage | <input type="radio"/> Unfulfilled expectations | <input type="radio"/> 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?

FEMALE:

Are you currently pregnant? Yes _____ No _____

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	Stiffness	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

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		

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? _____

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.

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

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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)	

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 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