



New Patient Intake Form

Today's Date _____

Name _____ Date of Birth _____

Age _____ Telephone (H) _____ (W) _____

Full Address _____

Email _____ Occupation _____

Marital Status _____ # of Children _____

Emergency Contact _____

How did you learn about the clinic? _____

This record of your medical history is confidential. Information it contains will not be released to any person unless you authorize the Oakville Naturopathic Clinic to do so.

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

1 _____

2 _____

3 _____

Have you had any other major conditions?

Medical Doctor _____ M.D. Phone _____

Please list *all* allergies (food, environmental, prescription drug)

Successful health care and preventative medicine are only possible when the doctor has a complete understanding of the patient physically, mentally, and emotionally. Your time, thoughtfulness and honesty will greatly assist my understanding of your health care needs.

Please list all current medications and their dosages
(prescription, over-the-counter, nutritional supplements, herbal medicines, etc.)

Please indicate any serious conditions, illnesses, injuries, surgeries, and/or hospitalizations that you have had. Include approximate dates.

X-Ray or special tests you have done (X-Ray, MRI, CT scan, EEG, ECG, endoscopy, colonoscopy, mammogram, ultrasound, other).

Weight gain/loss? Yes No + / - _____lbs

Exercise? Yes No How often? _____

Caffeine intake? Yes No How often? _____

Tobacco use? Yes No How often? _____

Alcohol use? Yes No How often? _____

Recreational Drugs? Yes No How often? _____

Headaches? Yes No How often? _____

Number of times antibiotics used in lifetime? _____

Any adverse reactions to vaccinations? _____

What other health care providers are you currently under the care of?

NAME	FOR WHAT CONDITION?
_____	_____
_____	_____

Describe a typical day's diet.

Breakfast _____

Lunch _____

Supper _____

Snacks _____

Beverages (and total quantity) _____

How many glasses of water do you drink in a day? _____

How often do have a bowel movement? _____

Do you get regular screening tests done by another doctor (pap, blood work)? Y / N

Blood type? A B AB O

Family History

	Father	Mother	Brothers	Sisters	Spouse	Child
Age (if living)						
Health (G=Good; P=Poor)						
Age at death (if deceased)						

Check (✓) those applicable

Alcoholism/drug abuse						
Allergies/Hay fever						
Arthritis						
Asthma/Eczema						
Autoimmune (MS, Lupus etc)						
Cancer						
Diabetes						
Epilepsy						
Glaucoma						
Gonorrhoea						
Gout						
Kidney Disease						
Heart Disease/Stroke						
High Blood Pressure						
Depression						
Other Mental Illness						
Pneumonia						
Psoriasis						
Syphilis						
Tuberculosis						
Other						
Cause of Death						

What are your treatment goals and expectations?

Is there anything that you feel is important that has not been covered?
