



Yorkville Integrative Health Clinic
94 Cumberland Street, Suite 905
Toronto, Ontario, M5R 1A3

T 416.920.4325
F 416.920.0044

www.downtownnaturopath.com

CONFIDENTIAL NEW PATIENT INTAKE FORM

<u>*GENERAL INFORMATION</u>	
Name: _____	Date of birth: _____ Age: _____
Address: _____	
Street: _____	
City/Province: _____	
Postal Code: _____	Phone: _____ Work: _____ Mobile: _____
Occupation: _____	Email: _____
Family physician: _____	Date of last physical: _____
Referred by: _____	Today's date: _____
How did you hear about us? _____	

<u>*What are your health concerns in order of importance?</u>

<u>*Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).</u>

***YOUR PAST MEDICAL HISTORY**

- | | |
|---|--|
| <input type="checkbox"/> ALLERGIES/HAYFEVER | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> ALCOHOLISM/DRUG ABUSE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> ULCER |
| <input type="checkbox"/> DEPRESSION | <input type="checkbox"/> COLD SORES |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> ANEMIA |
| <input type="checkbox"/> HEART ATTACK/STROKE/ANGINA | <input type="checkbox"/> FREQUENT ANTIBIOTIC USE |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> OTHER _____ |
| <input type="checkbox"/> HIGH CHOLESTEROL | |

IMMUNIZATIONS you have had?

- | | |
|---|---|
| <input type="checkbox"/> Flu shot | <input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus) |
| <input type="checkbox"/> Haemophilus, influenza B | <input type="checkbox"/> MMR (measles, mumps, rubella) |
| <input type="checkbox"/> Hepatitis A | <input type="checkbox"/> Polio |
| <input type="checkbox"/> Hepatitis B | <input type="checkbox"/> Small pox |
| <input type="checkbox"/> Tetanus booster; when? _____ | <input type="checkbox"/> Other |

Please indicate if any caused adverse reactions:

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations along with approximate dates?

*Do you have any allergies (medicines, environmental, food etc.)?

***FAMILY HEALTH HISTORY**

Includes parents, grandparents, brothers, sisters

- | | |
|---|---|
| <input type="checkbox"/> ALLERGIES/HAYFEVER | <input type="checkbox"/> HIGH CHOLESTEROL |
| <input type="checkbox"/> ASTHMA | <input type="checkbox"/> HEPATITIS |
| <input type="checkbox"/> ALCOHOLISM/DRUG ABUSE | <input type="checkbox"/> THYROID DISEASE |
| <input type="checkbox"/> CANCER | <input type="checkbox"/> ARTHRITIS |
| <input type="checkbox"/> DEPRESSION/MENTAL ILLNESS | <input type="checkbox"/> KIDNEY DISEASE |
| <input type="checkbox"/> DIABETES | <input type="checkbox"/> GLAUCOMA |
| <input type="checkbox"/> HEART ATTACK/STROKE/ANGINA | <input type="checkbox"/> OSTEOPOROSIS |
| <input type="checkbox"/> HIGH BLOOD PRESSURE | <input type="checkbox"/> OTHER _____ |

***LIFESTYLE INFORMATION**

Do you follow a regular exercise program? YES NO

What do you do for exercise? How much? How often?

Tobacco – type and amount per day?

Caffeine – type and amount per day (includes coffee, tea, pop)?

How much alcohol do you drink per day/week (please specify)?

Recreational drugs – type and frequency of use?

How many glasses of water do you drink per day?

Do you miss meals? If yes, which one? YES NO

On a scale of 1 to 10 (1=lowest and 10=highest) rate your: Energy level: /10
Stress level: /10

Describe your typical daily diet:

Breakfast

Lunch

Dinner

Snacks

Beverages

*ENVIRONMENT

Are you exposed to significant tobacco smoke (work, home, etc.)? YES NO

How would you describe the emotional climate of your home?

How stressful is your work or other aspects of your life?

How well do you handle these stresses?

*CLARIFYING YOUR GOALS

For your care to be successful to you, what do you see happening over the next 3 months?

How much do you think each of the following affects you personally? Please check box.

	Very much	Somewhat	Very little
Family & friends	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Love & romance	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Career & power	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Health & fitness	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Money & financial	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Environment & earth connection	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Personal growth & spirituality	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Fun & recreation	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

How motivated are you to invest the time, money and energy necessary to improve your health?

Thank you for taking the time to complete this form.