CANADIAN COLLEGE OF NATUROPATHIC MEDICINE

BRAMPTON NATUROPATHIC TEACHING CLINIC

Adult Intake

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

First Name _________________________ Last Name _________________________ Date ________________

Date of birth _________________________ (M/D/Y) Preferred Pronoun He She other_____

Address:____

____

E-mail Address:____

Telephone number: Home:____________ Work:____________ Cell:________________

May we leave messages relating to your visits? Y / N Which Phone Number__________

Emergency contact: Name: ____

Phone number(s):_(_______)___________ or_(______)_____________ Relation:_________

How would you identify your gender identity (please check all appropriate boxes):

☐ Female ☐ Male ☐ Transgender _________ ☐ Alternative: ___________ ☐ Prefer not to answer

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

- ❑ A patient of the clinic (please provide name) _____________________________________
- ❑ My medical doctor/Specialist(please provide name) ________________________
  Do they practice at William Osler? Yes No Unsure
- ❑ Other Health Care Provider (please provide name): ____________________________________
  Do they practice at William Osler? Yes No Unsure
- ❑ Advertising (newspaper, brochure)
- ❑ Social Media (Facebook, Twitter etc.)
- ❑ CCNM Website
- ❑ CCNM Student, staff or faculty
- ❑ William Osler staff or corporate email, newsletter etc.
- ❑ William Osler website
- ❑ Other:_______________________________

Optional:

People living in Canada come from many different cultural and racial backgrounds. Are you:

- □ European
- □ Australian
- □ Asian (e.g. Chinese, Korean, Japanese)
- □ Aboriginal
- □ South Asian (e.g. Indian, Pakistani, Sri Lankan)
- □ Middle Eastern (e.g. Iranian, Afghan, Lebanese, Syrian, Turkish, Israeli, Palestinian, Arabian)
- □ Other, Please Specify___________________
- □ Caribbean/West Indian
- □ South American
- □ Latin American
- □ South East Asian (e.g. Vietnamese, Cambodian, Malaysian, Laotian, Filipino)
- □ African
- □ Prefer not to disclose

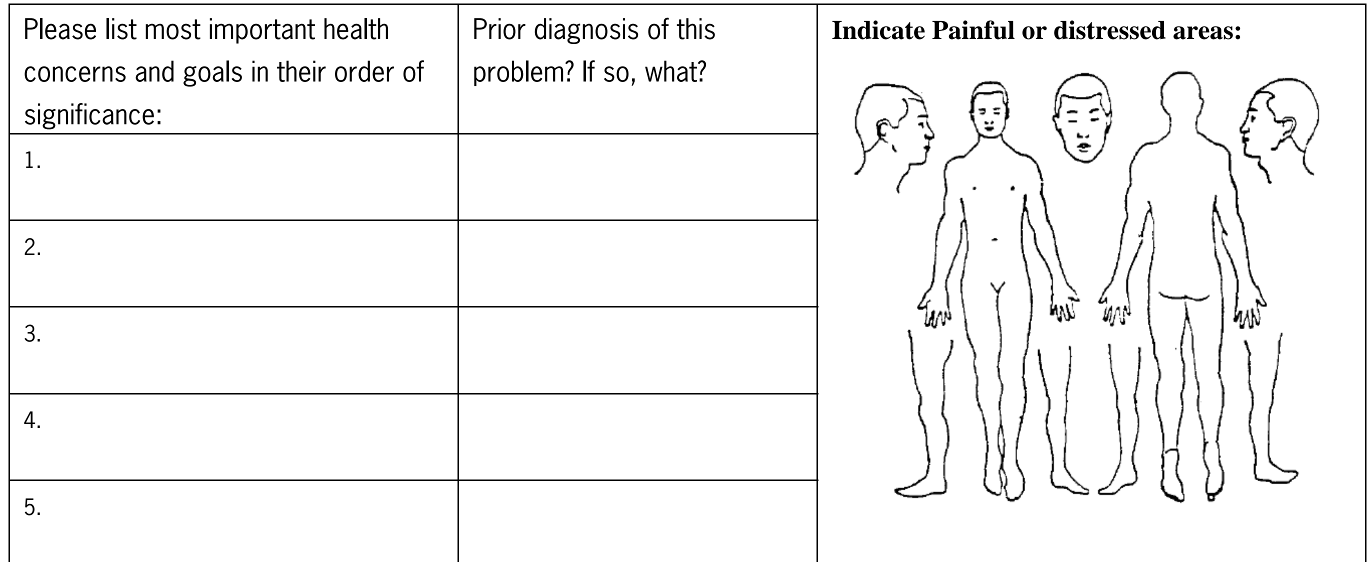
Have you ever consulted a Naturopathic doctor, an Acupuncturist, a Nutritionist or Counselor before? (Please circle)

Other health care providers you are seeing:

Name:______________________	Name:______________________	Name:______________________
Specialty:____________________	Specialty:____________________	Specialty:____________________
PH (__________)_____________	PH (__________)_____________	PH (__________)_____________
Date of last visit: _____________	Date of last visit: _____________	Date of last visit: ______________

Health Goals

What are your health concerns and goals, in order of importance to you:



Please list most important health concerns and goals in their order of significance:	Prior diagnosis of this problem? If so, what?	**Indicate Painful or distressed areas:**
1.		
2.		
3.		
4.		
5.		

Are you currently pregnant? Yes No (Please circle one) Due date______

Are you currently lactating? Yes No (Please circle one)

Medical history

How would you describe your general state of health? Excellent Good Fair Poor

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

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

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

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

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

1) ________________ 3) ________________ 5) ________________
2) ________________ 4) ________________ 6) ________________

Please list past prescription medications/natural health products:

____

____

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Aspirin, Tylenol, Advil or other pain relievers Y N P

Laxatives Y N P Antacids Y N P Diet pills Y N P

Birth control Y N P Type (please circle) Pills / Implants / Injections

Antibiotics Y N P Approximate number of prescriptions: ____________________

Alcohol—how much/day or week ______________________________________

Tobacco—form and amount/day ______________________________________

Caffeine—form and amount/day ______________________________________

Recreational drugs—what and how often______________________________________

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A

☐ Tetanus booster; when? ____________________ ☐ "Flu" ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox

Other ____

Please indicate if any caused adverse reactions: ______________________________

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y / N

Last time you had blood work done______________________________________

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes (✓)	Relation Please circle	Dates Resolved		Yes (✓)	Relation Please circle	Dates Resolved
Alcoholism/Drug addiction		Self F M S G C	Past Current	High Blood pressure		Self F M S G C	Past Current
Allergies		Self F M S G C	Past Current	Heart Disease		Self F M S G C	Past Current
Anemia		Self F M S G C	Past Current	Hepatitis		Self F M S G C	Past Current
Arthritis		Self F M S G C	Past Current	Headaches		Self F M S G C	Past Current
Asthma		Self F M S G C	Past Current	Kidney disease		Self F M S G C	Past Current
Cancer		Self F M S G C	Past Current	Stroke		Self F M S G C	Past Current
Diabetes		Self F M S G C	Past Current	Tuberculosis		Self F M S G C	Past Current
Eczema		Self F M S G C	Past Current	Osteoporosis		Self F M S G C	Past Current
Epilepsy		Self F M S G C	Past Current	Others:		Self F M S G C	Past Current
Depression/other Mental Illness		Self F M S G C	Past Current				

❑ I don't know my family medical history

Diet

Do you have any food allergies or intolerances? Please list.

1) ______________________________ 4) ______________________________
2) ______________________________ 5) ______________________________
3) ______________________________ 6) ______________________________

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?

____

Environment

Occupation ____

Hobbies ____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?

____

____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home heated?____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please describe:

____

____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)? ____

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?

____

____

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

____

____

____

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For file use only