

Patient Information Form

Last Name:		First Name:		Middle Name:
Date of Birth (MM/DD/YYYY):	Age:	Sex: F / M	Occupation:	
Contact Information				
Full Address:			City, Province:	
Postal Code:	Daytime phone number:	Evening phone number:	May we leave messages regarding your visit: Yes / No	
Email:				
Emergency Contact Information				
1) Last Name:		First Name:		Relationship:
Daytime phone number:		Evening phone number:		
2) Last Name:		First Name:		Relationship:
Daytime phone number:		Evening phone number:		
Other Healthcare Providers				
1) Name:		2) Name:		3) Name:
Specialty/Focus:		Specialty/Focus:		Specialty/Focus:
Phone number:		Phone number:		Phone number:
Date of last medical doctor visit:			Date of last physical exam:	
Please list regular screening tests performed by other physicians:				

How did you hear about this clinic?	
If referred, please state by whom:	
Have you been treated by a Naturopathic Doctor before? Yes / No	
If yes, by whom?	Date of last visit to ND:

Health Assessment Questionnaire

In your opinion, what are your most important health concerns:
1)
2)
3)
4)
5)

Medical History			
Are you currently pregnant? Yes / No		Are you trying to become pregnant: Yes / No	
Height:	Current Weight:	Past Min Weight:	Past Max Weight:
Vaccination / Immunization Record: Check all that apply Please note vaccinations in bold are considered routine as per the Ontario Childhood Immunization Schedule 2004			
<input type="checkbox"/> DPT (Diphtheria, Pertussis, Tetanus)	<input type="checkbox"/> BCG (Tuberculosis)	<input type="checkbox"/> Pneumococcal Conjugate (Meningitis/Pneumonia)	
<input type="checkbox"/> MMR (Measles, Mumps, Rubella)	<input type="checkbox"/> Hepatitis A	<input type="checkbox"/> Meningococcal C Conjugate (Meningitis)	
<input type="checkbox"/> Gardasil/Cervarix (HPV Vaccine)	<input type="checkbox"/> Hepatitis B	<input type="checkbox"/> Varivax/Varilrix (Chicken Pox)	
<input type="checkbox"/> Haemophilus Influenza B	<input type="checkbox"/> Polio	<input type="checkbox"/> Flu Vaccine	
<input type="checkbox"/> Other: _____			
Did any of your vaccines cause adverse reactions, if yes: _____			
Which of the following childhood illnesses have you had: Check all that apply			
<input type="checkbox"/> Asthma	<input type="checkbox"/> Polio	<input type="checkbox"/> Mumps	<input type="checkbox"/> Measles
<input type="checkbox"/> Rheumatic fever	<input type="checkbox"/> Scarlet fever	<input type="checkbox"/> Roseola	
<input type="checkbox"/> Rubella (German measles)	<input type="checkbox"/> Whooping cough	<input type="checkbox"/> Chicken Pox	
List any previously diagnosed medical conditions:		Treatment received:	Year
1)			
2)			
3)			
4)			
5)			
List all allergies (medications, foods, supplements, environmental, etc)		Reaction Type	
1)			
2)			
3)			
4)			
5)			

List all prescription drugs (oral contraceptive, etc), **over-the-counter medications** (pain killers, antacid, etc), **herbs and natural supplements** (vitamins, homeopathics, etc) **that you are taking**

Medication	Dosage	Start Date

Family Medical History					
Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information					
	Age	Health History		Age	Health History
Father			Mother		
Grandmother (Paternal)			Grandmother (Maternal)		
Grandfather (Paternal)			Grandfather (Maternal)		
Siblings		F / M	Children		F / M
		F / M			F / M
		F / M			F / M
		F / M			F / M

Dietary and Lifestyle Habits	
Exercise	How many times do you exercise per week? Never 1x 2x 3x 4x 5x >5x
	What type of exercise? Strength Building Aerobic/Cardio Flexibility
Diet	Are you currently dieting? Yes / No Is it a physician prescribed diet: Yes / No
	Do you have any dietary restrictions?
	On average, how many meals do you have in a day? 1 2 3 4 5 >5
Relationships and Sexuality	Are you currently sexually active? Yes / No
	Describe your sexuality: Heterosexual Homosexual Bisexual
	List contraceptive method(s) used, if any
	Do you experience any pain or discomfort during intercourse? Yes / No

Caffeine	# of cups of the following consumed in a day: Coffee: # _____ Tea: # _____ Cola: # _____
Alcohol	Do you consume alcohol? Yes / No If yes, how many drinks/week?
	What type(s) of alcohol do you consume?
Tobacco	Do you use tobacco? Yes / No If yes, how many/day?
	What type(s) of tobacco? How many years?
	Are you exposed to second hand smoke? Yes / No
Drugs	Do you currently use recreational drugs? Yes / No
	If yes, which kind(s) and how often?

Sleep	On average, how many hours of sleep do you get?
	Do you have trouble falling asleep? Yes / No
	Do you wake up during the night? Yes / No If yes, how many times/night?
Energy	On a scale of 1 (lowest) to 10 (highest), rate your energy level
Stress	What are some stressors in your life?
Toxins	Are you regularly exposed to any toxins or other hazards? Please specify

Is there any other important information that you would like me to know?
