Red Deer Wellness Clinic
G12, 5550-45 Street
Red Deer, AB T4N 1L1
403-346-1331

NEW PATIENT INTAKE FORM

I am aware of the time it takes to fill out such a lengthy intake form. However, your co-operation in completing it is essential to providing the highest standard of care. All information is confidential. PLEASE PRINT~~~ Thank you

PERSONAL INFORMATION

Name: ____ Today's Date: _____/ _____/ ______
(First) (Middle) (Last) dd mm yy

Date of Birth: _____/_____/_____ Age: ______ Gender: ______
dd mm yy

Home Address: ____

Home Telephone: ( )_______________ Cell: ( )_______________ Work: ( )______________

Email Address: ____

May we leave messages relating to your visits? Y N Preferred Number: _________________

Emergency contact (name): ______________________________ Phone: ( )__________________

How did you find out about our clinic?
- ✓referral – Whom may we thank? ____________________
- ✓newspaper/magazine
- ✓health food store
- ✓other ____________________

Family Physician: ______________________________________ Phone: ( )__________________

Other Health Care Provider(s): ____________________________ Phone: ( )__________________

____________________________ Phone: ( )__________________

CHIEF HEALTH CONCERNS

What are your health concerns? (List in order of importance to you):

1. ____
2. ____
3. ____
4. ____
5. ____

MEDICAL HISTORY

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

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

____

____

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

____

____

Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.).

____

____

____

Please list all past prescription medications.

____

____

____

How many times have you been treated with antibiotics within the last 5 years? __________

Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol – how much/day or week ____

Caffeine – form and amount/day ____

Recreational drugs – what and how often ____

Smoking history – past or present; how much _________________________________

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

If you are female, are you currently pregnant? Y N

FAMILY HEALTH HISTORY

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Who?		Who?
Allergies		High blood pressure	
Alcoholism		Kidney disease	
Asthma		Mental illness	
Arthritis		Mononucleosis	
Cancer (type)		Multiple Sclerosis	
Chronic Bronchitis		Osteoporosis	
Diabetes		Rheumatic Fever	
Depression		Skin diseases	
Drug abuse		Strep throat	
Emphysema		Stroke	
Hepatitis		Tuberculosis	
Heart disease		Other	

☐ I don't know my family medical history

DIET

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

___

___

___

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

___

___

Describe a typical day's diet.

Breakfast ___

Lunch ___

Dinner ___

Snacks ___

Beverages (and quantity) ___

LIFESTYLE/ENVIRONMENT

Occupation ___

Hobbies ___

___

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

___

___

Are you exposed to toxins or other hazards (work, home, hobbies, etc.)? Please describe.

___

___

How would you describe the emotional climate of your home?

___

___

___

How stressful is your work or other aspects of your life? How do you manage stress?

___

___

___

GENERAL HISTORY
Check the symptoms/conditions which apply to you:

✓Generals

_____ noticeable weight loss
_____ noticeable weight gain
_____ fever
_____ fatigue
_____ weakness

✓Skin

_____ rashes
_____ changes in hair/nails
_____ eczema
_____ boils
_____ colour change
_____ itching
_____ hives
_____ moles
_____ lumps
_____ dryness
_____ psoriasis

✓Head

_____ head injury
_____ hair loss
_____ headaches
_____ dandruff

✓Eyes

_____ redness
_____ specks
_____ double vision
_____ cataracts
_____ discharge
_____ spots
_____ excessive tearing
_____ glaucoma
_____ crossed eyes
_____ bothered by the sun
_____ pain
_____ flashing lights
_____ blurred vision
_____ blind spot

Do you wear glasses/contacts? ____________________________

Date of last eye exam? ____________________________________

✓Ears

_____ infection
_____ discharge
_____ ringing in ears (tinnitus)
_____ earaches
_____ vertigo
_____ hearing loss

Do you use hearing aids? _________________________________

Date of last hearing test? _________________________________

✓Nose and Sinuses

_____ frequent colds
_____ nasal stuffiness
_____ loss of smell
_____ hay fever
_____ discharge
_____ sinus infections
_____ nosebleeds
_____ itching

✓Mouth and Throat

_____ dry mouth
_____ sore tongue
_____ spots/sores in mouth
_____ heat/cold intolerance
_____ lumps in neck
_____ tonsillitis
_____ stiff neck
_____ bleeding gums
_____ hoarseness
_____ dental cavities
_____ sore throat
_____ loss of taste
_____ enlarged thyroid

Date of last dental exam? _________________________________

✓Respiratory

_____ sputum
_____ hemoptysis
_____ wheezing
_____ asthma
_____ tuberculosis
_____ chest pain
_____ cough
_____ bronchitis
_____ emphysema
_____ pneumonia
_____ pleurisy
_____ difficulty breathing

Results of spirometry tests or other lung tests:

____

✓Cardiovascular

_____ rapid heart beat
_____ high blood pressure
_____ low blood pressure
_____ chest pain
_____ palpitations
_____ blueness of skin (cyanosis)
_____ slow heart beat
_____ heart murmurs
_____ rheumatic fever
_____ edema/swollen ankles
_____ difficulty breathing
_____ thrombophlebitis
_____ leg cramps
_____ cold hands/feet
_____ extremity numbness
_____ deep leg pain

Results of electrocardiogram or other heart tests:
____

✓Gastrointestinal

How often do you have a bowel movement in a day? ______________________________

_____ trouble swallowing
_____ heart burn
_____ excessive hunger/thirst
_____ poor appetite/thirst
_____ diabetes
_____ nausea
_____ indigestion
_____ ulcer
_____ hemorrhoids
_____ constipation
_____ diarrhea
_____ hypoglycemia
_____ abdominal pain
_____ regurgitation
_____ excessive bloating
_____ hernias
_____ food intolerance/allergy
_____ excessive belching
_____ passing of gas
_____ jaundice
_____ colitis
_____ vomiting
_____ hepatitis
_____ liver/gallbladder issues

✓Genito-Urinary

_____ dark-coloured urine
_____ excessive urination
_____ burning/pain on urination
_____ pus in urine
_____ urgency
_____ dribbling
_____ urinary infections
_____ blood in urine
_____ frequency at night
_____ kidney infection
_____ foul smelling urine
_____ hesitancy
_____ incontinence
_____ kidney stones

✓Musculoskeletal

_____ muscle or joint pains
_____ arthritis
_____ back pain
_____ broken bones
_____ general muscle weakness
_____ stiffness
_____ gout
_____ artificial joints/limbs
_____ muscle spasms/cramps
_____ joint swelling

✓Neurological

_____ fainting/blackouts
_____ weakness
_____ numbness/loss of sensation
_____ tremors/involuntary motion
_____ nervousness
_____ depression
_____ difficulties concentrating
_____ convulsions/seizures
_____ loss of balance
_____ paralysis
_____ tingling/pins and needles
_____ speech problems
_____ tension
_____ memory changes/loss
_____ irritability
_____ loss of sleep

✓Hematological

_____ anemia
_____ easy bleeding
_____ any past transfusions
_____ easy bruising

Any other conditions? ____
____

PLEAE NOTE THAT THIS FORM MUST BE SIGNED PRIOR TO YOUR 1ST APPOINTMENT

Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used, in order to stimulate the body's inherent healing capacity. During the appointment a thorough case history will be done, as well as a physical examination, urine sample and Naturopathic assessment.

It is very important that you inform your Naturopathic Doctor immediately of any disease process that you are suffering from, known allergies, and if you are on any medication or over the counter drugs. If you are pregnant, suspect you are pregnant or you are breast-feeding; please advise your Naturopathic Doctor immediately.

There are some slight health risks to treatment by Naturopathic medicine. These include, but are not limited to:

- Aggravation of pre-existing symptoms
- Allergic reactions to supplements or herbs
- Pain, bruising or injury from acupuncture or injection/IV therapies
- Fainting or puncturing of an organ with acupuncture needles

I understand that my identity will be protected and confidential at all times and if necessary, identifying information will be altered to protect my privacy. I understand that a record will be kept of the health services provided to me and other health care professionals may have access to my medical records, which I may choose to decline that access at any time. The record will not be released to others, unless so directed by myself or the law requires it. I understand that all my medical records will be kept securely by my Naturopathic Doctor and are made available at my request. If my primary Naturopathic Doctor moves his/her practice from the Red Deer Wellness Clinic, I will be notified of appropriate contact information to access my records. My medical records will be maintained and accessible for a minimum of:

- 10 years from the date of last record entry for an adult client; or
- 10 years after the date of last record entry for a minor client, or 2 years after the client reaches or would have reached the age of 18, whichever is longer.

The clinic provides access to a professional dispensary for you to purchase remedies that the Naturopathic Doctors have prescribed, but are NOT mandatory to purchase. Alternate options will be provided if available.

If an appointment is missed without 24 hour notice, I agree to give my credit card to reschedule an appointment. If I do not attend my next appointment, I agree to pay 50% the appointment cost. My card number will be kept confidential and destroyed appropriately.

I understand that the results are not guaranteed. I expect the Naturopathic Doctor to be able to anticipate and explain all known benefits, risks and alternatives to treatment. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, **except** for ___________________________________.

I intend this consent form to cover the entire course of treatment for my health conditions. I understand that I am free to voice my concerns or withdraw my consent and to discontinue participation in these procedures or treatments at any time.

Client's Name: (Please Print) ____

Signature of Client or Guardian: ____

Date: ________________________ Signature of Naturopathic Doctor _________________________________