Nature's Intentions Naturopathic Clinic
Dr. Sushma Shah, ND
1849 Yonge St. Suite 614, Toronto, ON, M4S 1Y2
416 913 4325 (HEAL)
http://www.naturesintentionsnaturopathy.com

Balanced healing for the body, mind and spirit.

PLEASE FILL IN THE REQUIRED INFORMATION IN BLUE / BLACK INK.

We appreciate your taking the time to fill out the intake form accurately. Your cooperation is essential for providing you the highest standard of care. Please note that all the information you provide is confidential.

REGISTRATION INFORMATION

Name: _____
(First) (Middle) (Last)

Appointment Date : _____/_____/_____
mm dd yy

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

Email Address to receive our online newsletters / specials and appointment reminders*
(*only at your request):
_____

Home Address: _____

City: _____ Postal Code: _____

Home Telephone: ( ) _____ Work: ( ) _____

May we leave messages on your home phone relating to our visits? Y N

Emergency contact (name): _____ Phone: ( ) _____

How did you hear out about us?

- ✔ Referral – Whom may we thank? _____
- ✔ Newspaper / magazine / Yellow pages
- ✔ Billboard
- ✔ Health food store
- ✔ Other _____

Family Physician: _____ Phone: ( ) _____

Other Health Care Providers: _____ Phone: ( ) _____

CHIEF HEALTH CONCERNS

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

1. _____
2. _____
3. _____
4. _____
5. _____

List any other concerns you may want to discuss:

_____
_____
_____

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

MEDICAL HISTORY

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

Please indicate if you have had any serious conditions, illnesses, injuries, surgical procedures (including cosmetic procedures) and any hospitalizations along with approximate dates:

_____
_____
_____

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

_____
_____

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

_____
_____
_____

Please list all past prescription medications:

_____
_____
_____

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How many times have you been treated with antibiotics? _____

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

Aspirin Laxatives Antacids Diet pills Birth control pills

Alcohol – how much / day or week _____
Caffeine – form and amount / day _____
Recreational drugs – what and how often _____

Please indicate what immunizations have you had (✔):

_____ DPT (diphtheria, pertussis, tetanus) _____ Haemophilus influenza B
_____ Hepatitis A
_____ Tetanus booster _____ "Flu"
_____ Hepatitis B
_____ MMR (measles, mumps, rubella) _____ Polio
_____ Small pox

Did you experience any adverse reactions to past immunizations? _____
_____

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

FAMILY HEALTH HISTORY

Indicate if a close relative (parent, child, sibling) had /has 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		Stoke	
Hepatitis		Tuberculosis	
Heart disease		Other	

❑ I don't know my family medical history

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GENERAL HISTORY

Check the symptoms / conditions which apply to you:

Generals

_____ Noticeable weight loss _____ Fatigue _____ Noticeable weight gain
_____ Weakness _____ Fever _____ Lowered immunity

Skin

_____ Rashes _____ Color change _____ Lumps
_____ Changes in hair / nails _____ Itching _____ Dryness
_____ Eczema _____ Hives _____ Psoriasis
_____ Boils / Cysts _____ Moles

Head

_____ Head injuries _____ Headaches _____ Migraines
_____ Hair loss _____ Dandruff

Eyes

_____ Redness _____ Pain _____ Discharge
_____ Specks/Floaters _____ Excessive tearing _____ Flashing lights
_____ Double vision _____ Glaucoma _____ Blurred vision
_____ Cataracts _____ Crossed eyes _____ Blind spots

Do you wear glasses / contacts? _____

Date of last eye exam? _____

Ears

_____ Infection _____ Ringing in the ears (tinnitus) _____ Vertigo
_____ Discharge _____ Earaches _____ Hearing loss

Do you use hearing aids? Y N

Date of last hearing test? _____

Nose and Sinuses

_____ Frequent colds _____ Hay fever _____ Nosebleeds
_____ Nasal stuffiness _____ Discharge _____ Itching
_____ Loss of smell _____ Sinus infections

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- **Mouth and Throat**

_____ Dry mouth	_____ Bleeding gums
_____ Sore tongue	_____ Hoarseness
_____ Spots / sores in mouth	_____ Dental cavities
_____ Heat / cold intolerance	_____ Sore throat
_____ Lumps in neck	_____ Loss of taste
_____ Tonsillitis	_____ Enlarged thyroid
_____ Stiff neck	_____ Cancer

Date of last dental exam? _____

- **Respiratory**

_____ Sputum	_____ Cough
_____ Coughing up blood	_____ Bronchitis
_____ Wheezing	_____ Emphysema
_____ Asthma	_____ Pneumonia
_____ Tuberculosis	_____ Pleurisy
_____ Chest pain	_____ Difficulty breathing

Results of spirometry tests or the lung tests: _____
_____

- **Cardiovascular**

_____ Rapid heart beat	_____ Slow heartbeat
_____ High blood pressure	_____ Heart murmurs
_____ Low blood pressure	_____ Rheumatic fever
_____ Chest pain	_____ Edema / swollen ankles
_____ Palpitations	_____ Difficulty breathing
_____ Blueness of skin (cyanosis)	_____ Cold hands / feet
_____ Thrombophlebitis	_____ Extremity numbness
_____ Deep leg pain	_____ Leg cramps

Results of electrocardiogram or other heart tests:

_____
_____

- **Gastrointestinal**

_____ Trouble Swallowing	_____ Hemorrhoids
_____ Heartburn	_____ Constipation
_____ Excessive Hunger / Thirst	_____ Diarrhea
_____ Poor Appetite / Thirst	_____ Hypoglycemia
_____ Diabetes	_____ Abdominal Pain
_____ Nausea	_____ Food Intolerance / Allergy

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_____ Vomiting
_____ Regurgitation
_____ Jaundice
_____ Hepatitis
_____ Colitis
_____ Hernias
_____ Excessive Belching
_____ Passing Of Gas
_____ Indigestion
_____ Liver Or Gallbladder Problems
_____ Ulcers
_____ Excessive Bloating

Frequency of bowel movements? _____
Color and size of stools? _____
Change in bowel habits? _____
Any recent bleeding or black tarry stools? _____

- **Genito-Urinary**
  - _____ Dark-Colored 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
  - _____ Nervousness
  - _____ Tremors / Involuntary Motion
  - _____ Tension
  - _____ Depression
  - _____ Difficulties Concentrating
  - _____ Convulsions / Seizures
  - _____ Loss Of Balance
  - _____ Paralysis
  - _____ Tingling / Pins And Needles
  - _____ Speech Problems
  - _____ Numbness / Loss Of Sensation
  - _____ Memory Changes / Loss
  - _____ Irritability
  - _____ Loss Of Sleep

- **Hematological**
  - _____ Anemia / Thalassemia traits
  - _____ Easy Bleeding
  - _____ Any Past Transfusions
  - _____ Easy Bruising

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Any other conditions/symptoms that are not listed above:

_____

_____

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 (with quantity)

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages _____

LIFESTYLE / ENVIROMENT

Occupation _____

Hobbies _____

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

_____

_____

_____

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

_____
_____
_____

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

_____
_____

What are your health goals?
Please list them in the order of priority.

_____
_____
_____
_____
_____

Thank you for taking time to complete this intake form. We look forward to working with you in your naturopathic care. Please return this form to our clinic before your visit so that we can do an evaluation with the given information and also work on your treatment protocol while you await your appointment.

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