Eglinton-Kennedy Foot Clinic

Naturopathic Intake Form

First Name: _____ Last Name: _____ Sex: _____

Address: _____ Apt/Unit No.: _____ Date of Birth: _____

City: _____ Province: _____ Postal Code: _____

Home No.: _____ Work No.: _____ Cell No.: _____

Email: _____ Marital Status: _____

Family Dr.: _____ Address: _____ Phone No.: _____

Emergency Contact: _____ Contact No.: _____ Relationship: _____

How did you hear about us? _____

Have you ever consulted with (Please check all that apply): □ Naturopathic Doctor □ Acupuncturist

Are you currently nursing? □ Yes □ No Are you currently pregnant? □ Yes □ No Due date: _____

What is the reason for your visit today? _____ How long has this bothered you? _____

What treatments have you tried? _____

Current prescribed medication, over-the-counter or natural health products: _____

Do you smoke? □ Yes □ No How much daily? _____ Do you drink alcohol? □ Yes □ No How many drinks daily? _____

Do you get regular screening tests (Pap, blood tests, etc.)? □ Yes □ No What tests? _____

Insurance Company: _____ Policy No.: _____ ID No.: _____

If you are not the primary member of the insurance, please provide the following:

Policy Holder Name: _____ Date of Birth: _____ Relationship: _____

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

Health concerns or goals:	**Previous diagnosis?**
1)	
2)	
3)	
4)	

Do you have any allergies (medication, environmental, food?) _____

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

Do you exercise regularly? What type, how much and how often? _____

Personal Medical History

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

Weight: _____ Height: _____ Have you lost weight recently? How much? _____

What is your typical diet like?

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Sleep patterns (include usual time of sleep and wake, naps, any difficulty falling or staying asleep):

_____

_____

What is your stress level like on a typical day? (On a scale of 10, 10 being unbearable): _____

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

1) _____ _____

2) _____ _____

3) _____ _____

4) _____ _____

Indicate the following you have or may have had:

Alcoholism / Drug Addiction	☐	High Blood pressure	☐
Allergies	☐	Heart Disease	☐
Anemia	☐	Hepatitis	☐
Asthma	☐	Headaches	☐
Cancer	☐	Kidney Disease	☐
Diabetes	☐	Stroke	☐
Eczema	☐	Tuberculosis	☐
Epilepsy	☐	Osteoporosis	☐
Depression / other mental illness	☐	Others:	_____

Family Medical History

Indicate below any health conditions that your family members have or may have had.

Relationship	Age	Age at death	Health Condition(s)
Father			
Mother			
Brothers			
Sisters			
Children			
Paternal Grandfather			
Paternal Grandmother			
Maternal Grandfather			
Maternal Grandmother			