aevi naturopathic

Healthy Families Wellness Centre
404 S Vickers St,
Thunder Bay, ON P7E 1J8
(807)-475-8454

NATUROPATHIC INTAKE FORM

Name: _____ Date: _____ Date of Birth: _____

Address: _____

Email: _____ Occupation: _____ Age: _____

Telephone Home: _____ Work: _____ Mobile:_____

Emergency contact Name: _____ Phone: _____ Relation: _____

Do you have health insurance with naturopathic medical coverage? ❑ Y ❑ N

How did you hear about this clinic: _____

Other health care providers:

1. Name: _____
   Profession: _____
   Clinic Name: _____
   Fax: _____
2. Name: _____
   Profession: _____
   Clinic name:_____
   Fax: _____
3. Name: _____
   Profession: _____
   Clinic Name: _____
   Fax: _____

CONTEXT OF CARE REVIEW

Successful health care and preventive medicine are only possible when the physician has a complete understanding of the patient physically, mentally and emotionally. The nature of your responses to the following questions will go a long way in assisting our understanding of your truest desires. Your time, thoughtfulness and honesty in completing this overview will greatly aid us to assist your health needs.

Why did you choose to come to Aevi Naturopathic?

_____

What do you know of our approach to wellness?

_____

What three (3) expectations do you have from this visit?

1. _____
2. _____
3. _____

What ***long term*** expectations do you have of your naturopathic doctor?

_____

What is your present level of commitment to address any underlying causes of your signs/symptoms that relate to your lifestyle?
(Rate from 0 to 10, with 10 being 100% committed)

0% 1 2 3 4 5 6 7 8 9 10 100%

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What behaviors/habits do you currently engage in regularly that you believe **support** your health? (Please list)

_____

_____

What potential **obstacles** do you foresee in addressing the lifestyle factors which are undermining your health and in adhering to the therapeutic protocols which we will be sharing with you?

_____

_____

Who will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

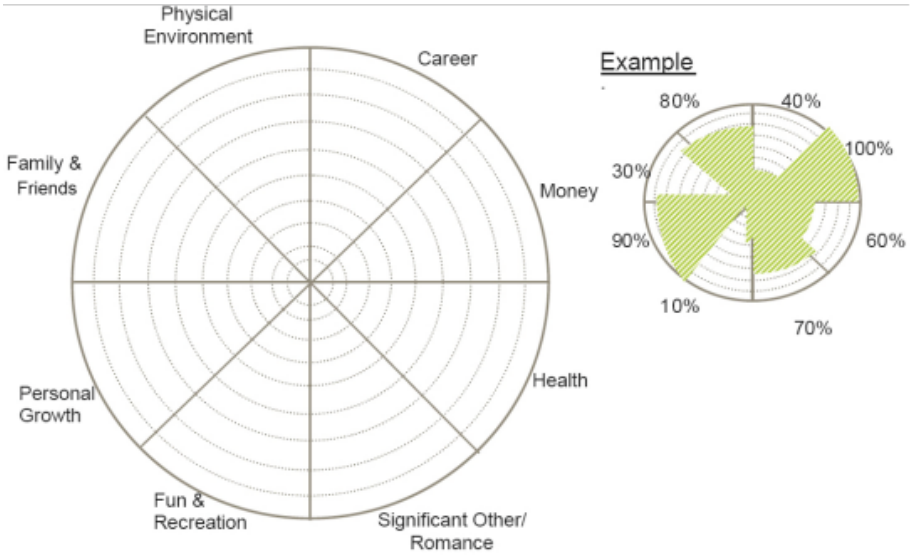
What do you LOVE to do? _____

WHEEL OF BALANCE

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are extremely happy in your career, shade the entire pie shape for career.

Do the same for each area, starting from the center point radiating outwards.



HEALTH INFORMATION

Please list your health concerns (physical, emotional, or psychological) in order of importance to you and the date of onset:

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

Please list your most stressful life experiences (physical or psychological):

1. _____ Age: _____
2. _____ Age: _____
3. _____ Age: _____

SUPPLEMENTS/DRUG MEDICATIONS

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Please list all **current** vitamins/minerals, herbs, or homeopathic remedies, along with the daily dose and how long you have taken it.

Supplement	Dose/day	How long?	Reason for Supplement
1.			
2.			
3.			
4.			
5.			
6.			

Please list all **current** medications (prescription and over-the-counter), the daily dose, how long you have taken it, and the reason for the prescription.

Medication	Dose/day	How long?	Reason for Medication
1.			
2.			
3.			
4.			
5.			
6.			

Are the medications well tolerated? ❑Y ❑N If no, please list the adverse reaction or side effect and from what medication:

_____

_____

In the last 10 years, approximately how many **courses of antibiotics** have you taken? _____

MEDICAL HISTORY

Please indicate if you have had any of the following **diagnostic tests** performed:

	Notable finding:		**Notable finding:**
Thyroid Panel ❑Y ❑N		Cholesterol ❑Y ❑N	
Liver Panel ❑Y ❑N		Hormone level ❑Y ❑N	
Complete Blood Count ❑Y ❑N		EKG ❑Y ❑N	
Blood Sugar test ❑Y ❑N		Chest x-ray ❑Y ❑N	
Colonoscopy ❑Y ❑N		Mammography ❑Y ❑N	

Please list any past **surgeries or hospitalizations** with the approximate dates:

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1. _____ _____
2. _____ _____
3. _____ _____

Please list all **past injuries** (ie. Broken bones, joint sprains, burns, falls, car accidents etc.) with dates:

1. _____ _____
2. _____ _____
3. _____ _____

List all **dental work** and the approximate date of the procedure (root canal, mercury or ceramic fillings, implants, caps, dentures):

1. _____ _____
2. _____ _____
3. _____ _____

What is your blood type? ❑ A+ ❑ B+ ❑ O+ ❑ AB+ ❑ A- ❑ B - ❑ O- ❑ AB-

FAMILY HISTORY

Please indicate whether any **family members** have had any of the following:

	Relation to You		Relation to You
❑ Alcoholism		❑ Diabetes	
❑ Allergies		❑ Drug abuse	
❑ Alzheimer's disease		❑ Heart disease	
❑ Arthritis		❑ High blood pressure	
❑ Asthma		❑ Kidney disease	
❑ Cancer (indicate type)		❑ Osteoporosis	
❑ Depression		❑ Stroke	
❑ Other mental illness		❑ Thyroid condition	

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LIFESTYLE

Please list all allergies (food, medication, environmental): _____

_____

Please describe the emotional climate of your home: _____

_____

_____

Rate your stress level (10 = high)

1 2 3 4 5 6 7 8 9 10

In your everyday life, your present faith/spiritual practices are (10 = very important):

1 2 3 4 5 6 7 8 9 10

Please rate your level of motivation to affect change in your health (10 = motivated).

1 2 3 4 5 6 7 8 9 10