Retail Store & Pharmacy:
1111 West Broadway
Vancouver BC V6H 1G1
604 733 5323

Health Centre:
G104 - 2480 Spruce
Vancouver, BC V6H 2P6
604 734 7760

Naturopathic Intake Form

Our professional association requires us to maintain contact information for our patient records. The information provided in this document is entirely confidential, used for internal office purposes only. We will not distribute your personal and private details.

Date: ___________________________________

Full Name

Date of Birth (MM/DD/YY)

Age

Address

City, Prov., Postal

Home #

Work #

Cell #

Email

Family Doctor

Family Doctor #

Emergency Contact

Emergency Contact #

❐ YES, please email me about important clinic information and updates.
❐ NO, I would not like to be contacted by email.

How did you hear about our Naturopathic services?

Health concerns in order of importance:

1.

2.

3.

4.

Past Medical History (including childhood diseases, surgeries, accidents, infectious diseases, degenerative conditions, allergies, hospitalization, and abuse of drugs/alcohol/cigarettes): Please use back if necessary

Please list all current medications (prescription, OTC, vitamins, herbs, and homeopathics):

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Please list any past prescription medications:

Please list any allergies you may have:

Family medical history (including close relatives, siblings, children):

Personal Health Habits

Height Weight Weight 1 Year Ago

Are you a smoker? Y N How many years? Packs/Day

Do you drink alcohol? Y N Type: Frequency:

Do you use recreational drugs? Y N Type: Frequency:

Do you drink coffee? Y N Cups/day: Do you drink tea? Y N Cups/day:

Do you exercise regularly? Y N Type: Frequency:

Hours of sleep/night: Do you stay asleep through the night? Y N Do you wake up feeling rested? Y N

Typical day's diet

Breakfast: ______________________

Lunch: ______________________

Dinner: ______________________

Beverages: ______________________

Snacks: ______________________

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Environment:

Occupation: ____________________

Hobbies: ____________________

Exposure to animals: ____________________

Exposure to toxins: ____________________

Women's Health

Are you currently pregnant? Y N
Number of months:
Number of pregnancies:
Number of miscarriages:
Number of abortions:
Difficulty conceiving? Y N
Number of viable births:
Date and result of last Pap smear:

Men's Health

Date and result of last prostate exam:

External Influences

How would you describe the emotional climate of your home?

How stressful is your work, or other aspects of your life? How well do you handle these stresses?

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

Finlandia Natural Pharmacy Health Centre

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Review of Systems – please check if you have experienced any of these in the last 12 months:

Skin and Hair

- ❒ Rashes
- ❒ Itching
- ❒ Dandruff
- ❒ Change in texture
- ❒ Poor healing sores
- ❒ Eczema
- ❒ Loss of hair
- ❒ Hives
- ❒ Pimples
- ❒ Recent Moles

Head

- ❒ Light headedness
- ❒ Fainting
- ❒ Loss of memory
- ❒ Difficulty concentrating
- ❒ Headaches/Migraines
- ❒ Sinus congestion

Eyes

- ❒ Eye pain
- ❒ Sensitive to light
- ❒ Loss of vision
- ❒ Blurred vision
- ❒ Difficulty seeing at night
- ❒ Itchy, inflamed or infected
- ❒ Glaucoma/Cataracts

Urinary

- ❒ Pain on urination
- ❒ Urgency of urination
- ❒ Impotency
- ❒ Frequent urination
- ❒ Kidney stones
- ❒ Inability to hold urine
- ❒ Blood in urine
- ❒ Irregular flow

Mouth

- ❒ Sores on lip/mouth
- ❒ Loss of taste
- ❒ Painful in gums or tongue

Throat

- ❒ Sore throat/hoarseness
- ❒ Difficulty swallowing

Nose

- ❒ Loss of smell
- ❒ Nose pain
- ❒ Nosebleeds

Lungs

- ❒ Shortness of breath
- ❒ Difficulty breathing
- ❒ Chronic cough
- ❒ Chronic phlegm/mucus
- ❒ Chronic infections

Immunity

- ❒ Frequent colds
- ❒ Use antibiotics

Cardiovascular

- ❒ High blood pressure
- ❒ Low blood pressure
- ❒ Irregular heart beat
- ❒ Phlebitis
- ❒ Palpitations
- ❒ Swelling of hands/feet
- ❒ Varicose veins
- ❒ Chest pain
- ❒ Cold hands/feet
- ❒ Blood clots
- ❒ Difficulty breathing

Ears

- ❒ Loss of hearing
- ❒ Loss of balance
- ❒ Dizziness
- ❒ Ear pain
- ❒ Ringing in ears
- ❒ Ear infections

Respiratory

- ❒ Cough
- ❒ Coughing blood
- ❒ Difficulty breathing when lying down
- ❒ Production of phlegm
- ❒ Bronchitis
- ❒ Pneumonia
- ❒ Asthma
- ❒ Pain on breathing

Gastro-Intestinal

- ❒ Nausea
- ❒ Constipation
- ❒ Abdominal pain
- ❒ Blood in stools
- ❒ Hemorrhoids
- ❒ Food cravings
- ❒ Vomiting
- ❒ Black stools
- ❒ Indigestion
- ❒ Mucus in stools
- ❒ Gas
- ❒ Poor appetite
- ❒ Diarrhea
- ❒ Bad breath
- ❒ Heartburn
- ❒ Rectal pain
- ❒ Bloating
- ❒ Difficult swallowing

_____ Number of bowel movements/day

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Informed Consent

Statement of Acknowledgement

Printed Name: ____

As a patient of this Health Centre, I have read the information and understand that the form of medical care is based on alternative and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided in complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some herbs; pain, fainting, bruising, or injury from venipuncture or acupuncture; muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice, and that I am not an agent of any private, local, county, provincial, or federal agency attempting to gather information with so stating. I accept full responsibility for any fees incurred during care and treatment.

______________________	______________	______________________
SIGNATURE	DATE	WITNESS