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PATIENT INTAKE FORM

Full Name: _____

Date of birth (dd/mm/yyyy): _____ Age: _____ Sex: M F

Full address: _____

Email address: _____

Telephone: (home) _____ (work) _____ (cell) _____

May we leave messages relating to your visits? Y / N

Emergency Contact: _____ () _____
Full Name Relation Telephone

Name of Medical Doctor: _____ Tel: () _____

Date of last visit to a Medical Doctor: _____ Date of last physical: _____

Other health care providers you are seeing:

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

() _____ () _____ () _____

Extended Health Care Carrier (if applicable): _____

How or by whom were you referred to this clinic? _____

Have you been treated by a Naturopathic Doctor (ND) before? Y N

If yes, by whom? _____ When? _____

Health Concerns

What is your primary health concern?

How long have you had this condition? _____

What specialist(s) have you seen, if any?

How has this condition been treated until now?

Can you trace the origin of the present illness to any particular circumstances, accident, illness, incident, mental upset or unusual stress in you life? If yes, please explain.

Additional Health Concerns and Health Goals

What else would you like to see changed in your health? List all other health concerns or goals in order of importance to you. Indicate the month and year each particular health concerned started, if possible.

	Health Concern/Goals	Month/Year	Present Treatment/Comments
1			
2			
3			
4			
5			

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

How long has it been since you experienced excellent health? _____

Every disease, serious illness, accident, physical or emotional trauma and drug leaves its mark and remains as a weak point in our body's system. Homeopathic medicine takes into account details of the past and will work to eliminate these weak points to strengthen your body. That is why it is necessary for us to know about all the ailments you have suffered from in the past and the treatments you have taken.

Medical History

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

Please list any known allergies (medicines, environmental, etc.):

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

Please list past prescription medications.

Approximately how many times have you been treated with antibiotics? _____

Please list all immunizations that you have received:

Please check	√	Please check	√
Measles Mumps Rubella (MMR)		Tetanus booster	
Diphtheria Pertussis Tetanus (DPT)		Hepatitis A	
Polio		Hepatitis B	
H. influenza B		Flu vaccine	
Small pox		Chicken pox	
Yellow fever		Typhoid	
Other:		Other:	

Was there any serious reaction to any of the above vaccinations? (please explain)

Family History

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

	Who?		Who?
Allergies		Depression	
Asthma		Other mental illness	
Heart disease		Drug abuse/alcoholism	
High blood pressure		Kidney disease	
Cancer		Other	
Diabetes			

I don't know my family medical history

Personal Profile

Height: _____ Present weight: _____ Goal weight: _____

If your present weight is different than your desired weight, how long has it been since you were your normal or goal weight? _____

Marital status: _____ How long have you been married (if applicable)? _____

Number of Children (if applicable): _____

Occupation: _____

Average number of hours worked in a week: _____

Stress of your work (0 none, 10 extremely stressful): _____

Do you like your work? Y N

If No, why not? _____

What are your hobbies? _____

Personal Habits and Lifestyle

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 _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often _____

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

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

Dietary Habits

Diet: Non Vegetarian Vegetarian Vegan For how long? _____

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

Describe a typical day's diet:

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages (and total quantity) _____

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

Thank you! It's time for your healing journey to begin...