



ADULT INTAKE FORM

CALGARY CENTRE FOR NATUROPATHIC MEDICINE

PH: (403) 270 - 9355 200, 110 Point McKay Cres. NW, Calgary, AB T3B 5B4

www.calgarynaturopathic.com

Patient Privacy: *Patient information will never be disclosed or sold to an individual or company. The information you provide herein is used solely by CCNM for administrative, diagnostic and/or treatment purposes, and will be treated in the strictest confidence.*

Name: _____ Date: _____

Address: _____

City: _____ PROV/ST _____ Postal/Zip Code _____

PH: (Home) _____ (Bus) _____

Best time to call: _____ Time Zone _____ E-mail address: _____

Age: _____ Date of Birth: _____ Gender: Female _____ Male _____

Education: _____

Married _____ Separated _____ Divorced _____ Widowed _____ Single _____ Partnership _____

Live with: Spouse _____ Partner _____ Parents _____ Children _____ Friends _____ Alone _____

Occupation: _____ Hours per week _____ Retired _____

Employer: _____

Work Address: _____

How did you hear about CCNM? _____

Have you any family members that are patients at CCNM? _____

Name of next of kin or other to contact in an emergency: _____

Relationship to you: _____ Phone # _____

Address: _____



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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 along 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 CCNM?

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 CCNM 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%

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

What behaviours / habits do you currently engage in regularly that you believe are self-destructive? (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?



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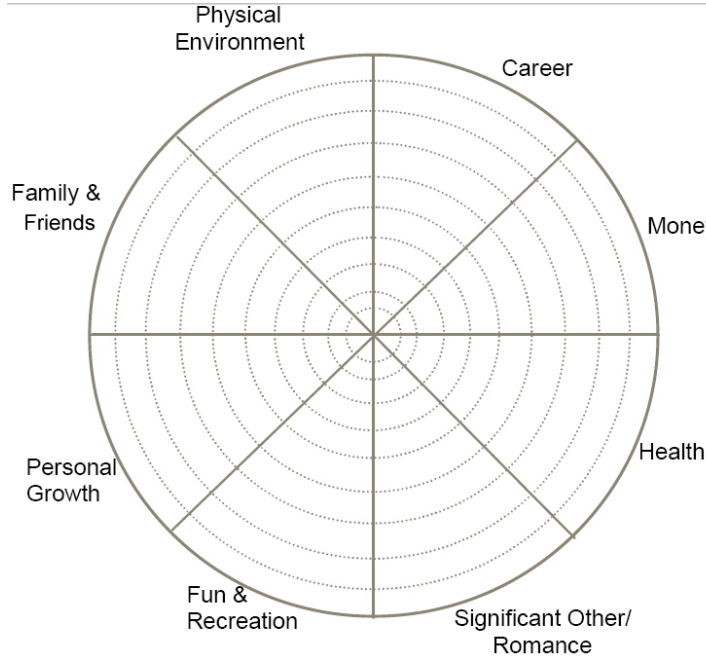
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WHEEL OF BALANCE

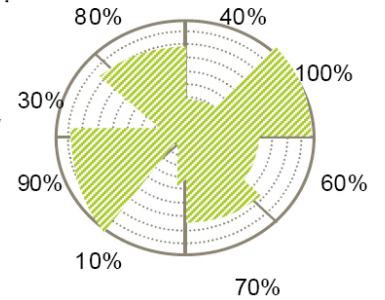
Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

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.



Example



Are you currently receiving health care? **Y N** If yes, where and from whom:

If no, when and where did you last receive medical or health care?

What was the reason? _____

What are your most important health problems? List as many as you can in order of importance:

- 1) _____
- 2) _____
- 3) _____
- 4) _____
- 5) _____
- 6) _____
- 7) _____

Do you have any known contagious diseases at this time? **Y N**

If yes, what? _____



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FAMILY HISTORY

Do you have a family history of any of the following? *(Please circle all that apply)*

Cancer	Diabetes	Heart Disease	High Blood Pressure
Kidney Disease	Epilepsy	Arthritis	Glaucoma
Tuberculosis	Stroke	Anaemia	Mental Illness
Asthma	Hay Fever	Hives	

Any other relevant family history? _____

What is your heritage: German _____ Nordic _____ Celtic _____ Other _____

CHILDHOOD ILLNESSES *(Please circle all that apply)*

Scarlet Fever	Diphtheria	Rheumatic Fever
Mumps	Measles	German Measles

HOSPITALIZATION, SURGERY, IMAGING

What hospitalizations, surgeries, X-Rays, CAT Scans, EEG, EKG's have you had?

_____	Year	_____	_____	Year	_____
_____	Year	_____	_____	Year	_____
_____	Year	_____	_____	Year	_____

ALLERGIES

Are you hypersensitive or allergic to any drugs? _____

Any foods? _____

Any environmental influences or chemicals? _____

CURRENT MEDICATIONS

Do you take or use?

Laxatives	Y	N	Pain relievers	Y	N	Antacids	Y	N
Cortisone	Y	N	Appetite suppressants	Y	N	Antibiotics	Y	N
Tranquilizers	Y	N	Thyroid medication	Y	N	Sleeping Pills	Y	N

Please list any prescription and OTC medications, vitamins or other supplements you are taking:

_____	_____
_____	_____
_____	_____



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GENERAL

Height: _____ Weight: _____ lbs. Weight 1 year ago: _____ lbs.
Maximum Weight: _____ When: _____
When during the day is your energy the best? _____ worst? _____

TYPICAL FOOD INTAKE

Breakfast: _____
Lunch: _____
Dinner: _____
Snacks: _____
To drink: _____

HABITS

Main interests and hobbies? _____

Do you exercise? **Y N**
If yes, what kind? _____ How often? _____
Watch television? **Y N** How many hours? _____
Do you read? **Y N** How many hours? _____
Do you have a religious or spiritual practice? **Y N** If yes, what? _____
Smoked previously? **Y N** How many years? _____ How many cigarettes a day? _____

FOR THE FOLLOWING, PLEASE CIRCLE

Y = A condition you have now

N = Never had

P = Significant problem in the past

Average 6 - 8 hours of sleep daily	Y	N		Enjoy your work	Y	N	
Sleep well	Y	N		Take vacations	Y	N	
Awaken rested	Y	N		Spend time outside	Y	N	
Have a supportive relationship	Y	N		Eat 3 meals a day	Y	N	
Have a history of abuse	Y	N		Go on diets often	Y	N	
Experienced major traumas	Y	N	P	Eat out often	Y	N	
Have used recreational drugs	Y	N	P	Drink coffee	Y	N	P
Been treated for drug dependence?	Y	N	P	Drink black tea/green tea	Y	N	P
Use alcoholic beverages	Y	N	P	Drink cola /other pop	Y	N	P
Been treated for alcoholism	Y	N	P	Drink or eat refined sugar	Y	N	P
				Add salt to food	Y	N	P

REVIEW OF SYSTEMS

Mental / Emotional

Treated for emotional problems	Y	N	P	Depression	Y	N	P
Mood Swings	Y	N	P	Anxiety or nervousness	Y	N	P



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Considered or Attempted suicide	Y	N	P	Tension	Y	N	P	
Poor concentration	Y	N	P	Memory problems	Y	N	P	
Immune								
Reactions to immunizations	Y	N	P	Reactions to vaccinations	Y	N	P	
Chronic Fatigue Syndrome	Y	N	P	Chronic infections	Y	N	P	
Chronically swollen glands	Y	N	P	Slow wound healing	Y	N	P	
Endocrine								
Hypo / hyperthyroid	Y	N	P	Heat or cold intolerance	Y	N	P	
Hypoglycaemia	Y	N	P	Diabetes	Y	N	P	
Excessive thirst	Y	N	P	Excessive hunger	Y	N	P	
Fatigue				Seasonal depression	Y	N	P	
Neurologic								
Seizures	Y	N	P	Paralysis	Y	N	P	
Muscle weakness	Y	N	P	Numbness or tingling	Y	N	P	
Loss of memory	Y	N	P	Easily stressed	Y	N	P	
Vertigo or dizziness	Y	N	P	Loss of balance	Y	N	P	
Skin								
Rashes	Y	N	P	Eczema, Hives	Y	N	P	
Acne, Boils	Y	N	P	Itching	Y	N	P	
Colour change	Y	N	P	Perpetual hair loss	Y	N	P	
Lumps	Y	N	P	Night sweats	Y	N	P	
Head								
Headaches	Y	N	P	Head injury	Y	N	P	
Migraines	Y	N	P	Jaw / TMJ problems	Y	N	P	
Eyes								
Spots in Eyes	Y	N	P	Cataracts	Y	N	P	
Impaired vision	Y	N	P	Wear glasses or contacts	Y	N	P	
Blurriness	Y	N	P	Eye pain / strain	Y	N	P	
Colour blindness	Y	N	P	Tearing or dryness	Y	N	P	
Double vision	Y	N	P	Glaucoma	Y	N	P	
Ears								
Impaired hearing	Y	N	P	ringing	Y	N	P	
Earaches	Y	N	P	Dizziness	Y	N	P	
Nose and Sinuses								
Frequent colds	Y	N	P	Nose Bleeds	Y	N	P	
Stiffness	Y	N	P	Hay fever	Y	N	P	
Sinus problems	Y	N	P	Loss of smell	Y	N	P	



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Mouth and Throat

Frequent sore throat	Y	N	P	Copious saliva	Y	N	P
Teeth grinding	Y	N	P	Sore tongue / lips	Y	N	P
Gum problems	Y	N	P	Hoarseness	Y	N	P
Dental cavities	Y	N	P	Jaw clicks	Y	N	P

Neck

Lumps	Y	N	P	Swollen glands	Y	N	P
Goiter	Y	N	P	Pain or stiffness	Y	N	P

Respiratory

Cough	Y	N	P	Sputum	Y	N	P
Spitting up blood	Y	N	P	Wheezing	Y	N	P
Asthma	Y	N	P	Bronchitis	Y	N	P
Pneumonia	Y	N	P	Pleurisy	Y	N	P
Emphysema	Y	N	P	Difficulty breathing	Y	N	P
Pain on breathing	Y	N	P	Shortness of breath	Y	N	P
Shortness of breath at night	Y	N	P	Shortness of breath when lying down	Y	N	P
Tuberculosis	Y	N	P				

Cardiovascular

Heart disease	Y	N	P	Angina	Y	N	P
High / Low Blood Pressure	Y	N	P	Murmurs	Y	N	P
Blood clots	Y	N	P	Fainting	Y	N	P
Phlebitis	Y	N	P	Palpitations / Fluttering	Y	N	P
Rheumatic Fever	Y	N	P	Chest Pain	Y	N	P
Swelling in ankles	Y	N	P				

Gastrointestinal

Trouble swallowing	Y	N	P	Heartburn	Y	N	P
Change in thirst	Y	N	P	Abdominal pain or cramps	Y	N	P
Change in appetite	Y	N	P	Belching or passing gas	Y	N	P
Nausea / vomiting	Y	N	P	Constipation	Y	N	P
Ulcer	Y	N	P	Diarrhoea	Y	N	P
Jaundice (yellow skin)	Y	N	P	Bowel Movements: How often? _____			
Gall Bladder disease	Y	N	P	Is this a change?	Y	N	
Liver Disease	Y	N	P	Black stools	Y	N	P
Hemorrhoids	Y	N	P	Blood / Mucus in stools	Y	N	P



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Urinary

Pain on urination	Y	N	P	Increased frequency	Y	N	P
Frequency at night	Y	N	P	Inability to hold urine	Y	N	P
Frequent infections	Y	N	P	Kidney stones	Y	N	P

Musculoskeletal

Joint pain or stiffness	Y	N	P	Arthritis	Y	N	P
Broken bones	Y	N	P	Weakness	Y	N	P
Muscle spasms or cramps	Y	N	P	Sciatica	Y	N	P

Blood / Peripheral Vascular

Easy bleeding or bruising	Y	N	P	Anemia	Y	N	P
Deep leg pain	Y	N	P	Cold hands / feet	Y	N	P
Varicose veins	Y	N	P	Thrombophlebitis	Y	N	P

Male Reproduction

Hernias	Y	N	P	Testicular masses	Y	N	P
Testicular pain	Y	N	P	Prostate disease	Y	N	P
Venereal disease	Y	N	P	Discharge or sores	Y	N	P
Are you sexually active?	Y	N		Chlamydia?	Y	N	P
Sexual orientation: _____				Gonorrhoea	Y	N	P
Impotence	Y	N	P	Condyloma	Y	N	P
Premature ejaculation	Y	N	P	Herpes	Y	N	P
Birth control: Type? _____				Syphilis	Y	N	P

Female Reproduction / Breasts

Age at first menses? _____				Date of last annual exam / PAP _____			
Age at last menses? (if menopausal) _____				Are cycles regular	Y	N	
Length of cycle _____ days				Bleeding between cycles	Y	N	P
Duration of menses _____ days				Pain during intercourse	Y	N	P
Painful menses	Y	N	P	Clotting	Y	N	P
Heavy or excessive flow	Y	N	P	Discharge	Y	N	P
PMS	Y	N	P	Birth control	Y	N	P
If yes, what are your symptoms? _____ _____				What type: _____			
				Number of pregnancies: _____			
				Number of live births: _____			
Endometriosis	Y	N	P	Number of miscarriages: _____			
Ovarian cysts	Y	N	P	Number of abortions: _____			



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Difficulty conceiving	Y	N	P	Menopausal symptoms	Y	N	P
Cervical Dysplasia	Y	N	P	Abnormal PAP	Y	N	P
Sexual difficulties	Y	N	P	Chlamydia	Y	N	
Gonorrhoea	Y	N	P	Condyloma	Y	N	P
Herpes	Y	N	P	Syphilis	Y	N	P
Are you sexually active?	Y	N	P	Sexual orientation: _____			
Do you do breast self exams?	Y	N	P	Breast lumps	Y	N	P
Breast pain / tenderness	Y	N	P	Nipple discharge	Y	N	P

Is there anything else you would like to add or comment on?

Cancellation Policy:

We will call to confirm 48 - 72 hours prior to your scheduled appointment, and we require a return confirmation phone call from you.

Appointments cancelled with less than 24 hours notice may be charged \$35. Appointments cancelled the same day or missed appointments will be charged the full appointment fee.

I understand and agree: _____ **Signature** Date: _____

Thank you for your time and effort.

We at CCNM look forward to providing you with the best possible care!