NATCAN

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Integrative Medicine – Intake Form

Please take 15-20 minutes to complete the following form. It will provide us with the background information we need to better serve you. Please email completed form to **info@natcanintegrative.ca** prior to your first appointment. *Thank you for your trust!!!*

Contact Information:

Name _____ Occupation _____

Gender _____ Employer _____

Date of Birth _____ Work Phone # _____

E-mail Address _____ Emergency Contact _____

Home Phone # _____ Emergency Contact # _____

Cell _____ Contact Relationship _____

Home Address _____ OHIP Number _____

How would you like to receive communication via email?:

Appointment reminders and communication from our front desk staff about your appointment - YES/NO

Communication from your integrative practitioners about your care - YES/NO

Our Monthly newsletter including seminars and special events - YES/NO

How did you hear about NatCan? (Please provide the name and/or source): _____

Care Co-ordination (i.e. Specialist/Medical Provider (MP) includes but not limited to: Dermatologist, Optometrist, Fertility Doctor, Gastroenterologist, Cardiologist etc.):

Medical Doctor _____ Specialist/MP _____

Medical Doctor # _____ Specialist/MP # _____

Medical Doctor Address _____ Specialist/MP Address _____

Email _____ Email _____

Dentist _____ Specialist/MP _____

Dentist # _____ Specialist/MP # _____

Dentist Address _____ Specialist/MP Address _____

Email _____ Email _____

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Health Priorities / Chief Concerns:

List your main heath concerns (or reasons for visiting the clinic) in order of importance.

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

Have you received integrative care before?
___Massage ___Chiropractic ___Naturopathic Medicine ___Counselling ___Physiotherapy Other: _____

Did another health care practitioner refer you for treatment? Name: _____

What service/discipline would you like NatCan to offer? _____
In terms of healthcare, what means the most to you? (i.e. rapport/comfort with practitioner, quality of service, education etc.) _____

Do you currently feel pain or discomfort? _____
Have you had a similar symptom in the past? _____
How was this past symptom treated? _____
Does the Pain Travel?: YES/NO Where? _____
What is the nature of the pain (i.e stabbing, dull, burning, pins and needles, aching, stiff & tight)?
_____
Does anything aggravate or relieve the pain? _____
Does the pain wake you from your sleep?: YES/NO
Is the pain worse in the morning?: YES/NO
Does the pain get better during the day?: YES/NO
Does your work or daily activities interfere with the pain? _____
Is there anything else that you think may be important? _____

Medical History:

How would you describe your general state of health? ___Excellent ___Good ___Fair ___Poor

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Medical conditions: Please indicate any serious illnesses, conditions, or reasons for hospitalizations.

Medical Condition/ Hospitalization	Date of Diagnosis/ Diagnosed by whom	Is the condition still present?	Symptoms

Allergies or Food sensitivities: Please indicate any allergies and/or serious food sensitivities.

Allergy/Sensitivity	Severity of reactions

Medications/Supplements: Please list all current medications/supplements.

Medication/Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

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#102 - 3905 Major Mackenzie Drive West, Woodbridge, ON, L4H 4J9

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Past Medications/Supplements: Please list all past medications/supplements in the last 5 years.

Medication/Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

Have you taken antibiotics within the last 5 years?: YES/NO

Vaccinations: Please indicate which vaccinations you have received.

Vaccination against:		Age	Side Effects/Hospital Admittance
Measles, Mumps, Rubella (MMR)			
Diphtheria, Pertussis, Tetanus (DPT)			
Haemophilus Influenza B (Hib)			
Chicken Pox (Varicella Zoster)			
Rabies			
Hepatitis A			
Hepatitis B			
Tetanus			
Polio			
Flu			
Other:			

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Review of Systems:

Please list conditions or concerns that involve the following systems.

SKIN *(eg. eczema, psoriasis, hives, rashes)* _____

HEAD *(eg. headaches)* _____

EYES *(eg. itching, pain, infection, corrective lenses)* _____

EARS *(eg. wax, discharge, hearing impairment)* _____

NOSE *(eg. sinus problems, pain, nose bleeds)* _____

MOUTH *(eg. difficult dentition, cavities, loss of taste, problems swallowing)* _____

NECK *(eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)* _____

HEART *(eg. rheumatic fever, murmurs, chest pain)* _____

LUNGS *(eg. cough, asthma, wheezing)* _____

GASTROINTESTINAL *(eg. vomiting, swallowing, diarrhea, constipation)* _____

URINARY *(eg. pain, increased frequency, blood)* _____

MALE *(eg. hernias, pain or masses in scrotum/testes)* _____

FEMALE *(eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus)*

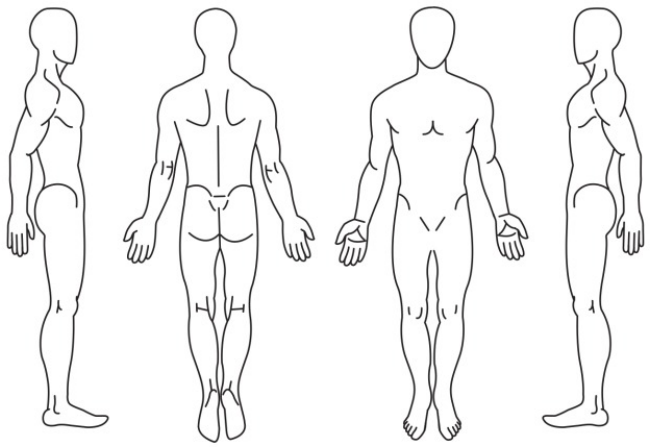
_____

MUSCLE AND SKELETON *(eg. joint pain, stiffness, weakness, back pain, fractures)*

_____

NEUROLOGICAL *(eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)* _____

Please indicate where you are feeling discomfort– provide as much detail as possible.



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Do you use/have any of the following?:

Substance		How often/How much/What brand/type?
Alcohol		
Cigarettes		
Recreational Drugs		
Aspirin/Tylenol/Advil		
Laxatives		
Ant-acids		
Diet Pills		
Coffee		
Black Tea		
Green Tea		
Birth control pill		
Birth control implants		
Birth control injections		
Metal implants		
Mercury Fillings		How many?
Resin Fillings		How many?
Other:		

What was the date of your last physical exam? _____

Have you ever had abnormal lab test results? Please indicate results:_____

Female:

Are you currently or could you be pregnant?: YES/NO How many weeks: _____

Have you ever been pregnant?: YES/NO How many times: _____ How many vaginal births: _____

C-Sections: _____

How old were you when you had your first period: _____ Have your periods been regular: _____

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(Female Cont'd)

Have you taken/used?

The birth control pill: YES/NO When: _____ **The patch:** YES/NO When: _____

An IUD: YES/NO When: _____ **Depo Provera injections:** YES/NO When: _____

Other: _____ When: _____

Are you currently?: ___Pre-menopausal ___Transitioning through menopause ___Post-menopausal

Have you/are you, taken/ing Hormone Replacement Therapy (HRT)?: YES/NO How long: _____

Family History:

Illness		Family Member	Complications/Severity
Allergies			
Asthma			
Diabetes			
Heart Disease			
Cancer			
Depression			
Other mental illness			
Kidney disease			
Infertility			
Post-partum depression			
High Blood Pressure			
Other			
Family History Unknown			

Lifestyle

Do you identify as: ___Straight ___Homosexual ___Bi-sexual ___Trans-gendered Other: _____

Do you have a strong emotional support network?: YES/NO Who: _____

Have you experienced any major trauma or loss in the past 5 years? _____

Have you experienced any other trauma or loss in your life? _____

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(Lifestyle Cont'd)

How would you currently rate your level of stress at this time?

__Minimal __Average __Considerable __Unbearable

What are the major causes of stress in your life at this time? *(check all that apply)*

__Financial __Career __Personal __Marriage/relationship __Health __Family __Spiritual

Other (please elaborate): _____

How does your stress manifest itself? _____

What type of coping mechanism to you employ to manage your stress? _____

What do you do for exercise/movement? *(Indicate type, frequency and time of day)*

_____

Do you have a history of concussion?: YES/NO Date:_____

How many hours per night do you sleep? _____ Nap? _____ Do you wake rested in the morning?: YES/NO

How old is your mattress? _____ Describe the comfort level of your pillow: _____

Do you enjoy your work/occupation?: YES/NO/SOMETIMES

How many hours per day do you spend on the following? Driving _____ Watching TV _____ Reading _____

In front of a computer _____ Work _____

When was your last vacation? _____

Do you actively participate in a spiritual discipline (church, synagogue, meditation, etc…)?: YES/NO

Dietary Habits

What time of day do you eat the following? Breakfast: _____ Lunch: _____ Dinner: _____ Snacks: _____

Do you consume the following? *(circle all that apply and indicate frequency)* –> Fresh Vegetables: _____

Fresh Fruit: _____ Cold-water Fish: _____ Tuna: _____ Canned goods: _____ Pop: _____

Milk: _____ Coffee: _____ Water: _____ Juice: _____ Processed Foods: _____

Microwavable meals: _____ Red meat: _____ Cheese: _____ Chocolate: _____

Aspartame: _____ Deli meats: _____ Fast Food: _____ Margarine: _____

Do you crave? *(circle all that apply)* –> Sugar I Chocolate I Salt I Crunchy foods I Other: _____

Do you have regular bowel movements?: YES/NO Do you have to strain for a bowel movement?: YES/NO

Do you regularly have loose stools?: YES/NO

Do you associate digestive difficulties with any particular foods?: YES/NO Which foods? _____

How many bowel movements do you have per day? _____

Additional Information– If there is any other relevant information pertaining to your health that was not covered in this intake please state it below: