BROOKLIN
NATUROPATH

Adult Patient Information Form

Last Name:		First Name:		Middle Name:
Date of Birth (MM/DD/YYYY):	Age:	Sex: F / M	Occupation:	
Contact Information				
Full Address:			City, Province:	
Postal Code:	Daytime phone number:	Evening phone number:	May we leave messages regarding your visit: Yes / No	
Email:				
Emergency Contact Information				
1) Last Name:		First Name:		Relationship:
Daytime phone number:		Evening phone number:		
2) Last Name:		First Name:		Relationship
Daytime phone number:		Evening phone number:		
Other Healthcare Providers				
1) Name: Specialty/Focus: Phone number:		2) Name: Specialty/Focus: Phone number:		3) Name: Specialty/Focus: Phone number:
Date of last medical doctor visit:		Date of last physical exam:		
Please list regular screening tests performed by other physicians:				

How did you hear about this clinic?	
If referred, please state by whom:	
Have you been treated by a Naturopathic Doctor before? Yes / No	
If yes, by whom?	Date of last visit to ND:

Health Assessment Questionnaire

In your opinion, what are your most important health concerns:
1)
2)
3)
4)
5)

Medical History			
If you are female, are you pregnant? Yes / No		**Are you trying to become pregnant:** Yes / No	
Height:	**Current Weight:**	**Past Min Weight:**	**Past Max Weight:**

Vaccination / Immunization Record: Check all that apply

Please note vaccinations in **bold** are considered routine as per the Ontario Childhood Immunization Schedule 2004

☐ **DPT (Diptheria, Pertussis, Tetanus)**	☐ BCG (Tuberculosis)	☐ **Pneumococcal Conjugate (Meningitis/Pneumonia)**
☐ **MMR (Measles, Mumps, Rubella)**	☐ Hepatitis A	☐ **Meningococcal C Conjugate (Meningitis)**
☐ Gardasil/Cervarix (HPV Vaccine)	☐ **Hepatitis B**	☐ **Varivax/Varilrix (Chicken Pox)**
☐ Haemophilus Influenza B	☐ **Polio**	
	☐ Flu Vaccine	
	☐ Other: _____	

Did any of your vaccines cause adverse reactions, if yes:

_____

Which of the following childhood illnesses have you had: Check all that apply

☐ Asthma	☐ Polio	☐ Mumps
☐ Rheumatic fever	☐ Scarlet fever	☐ Roseola
☐ Rubella (German measles)	☐ Whooping cough	☐ Measles
☐ Chicken Pox		

List any previously diagnosed medical conditions:	**Treatment received:**	**Year**
1)		
2)		
3)		
4)		
5)		

List all allergies (medications, foods, supplements, environmental, etc)	**Reaction Type**
1)	
2)	
3)	
4)	
5)	

List all prescription drugs (oral contraceptive, etc)**, over-the-counter medications** (pain killers, antacid, etc), **herbs and natural supplements** (vitamins, homeopathics, etc) **that you are taking**		
Medication	**Dosage**	**Start Date**

Family Medical History					
Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information					
	Age	**Health History**		**Age**	**Health History**
Father			**Mother**		
Grandmother (Paternal)			**Grandmother (Maternal)**		
Grandfather (Paternal)			**Grandfather (Maternal)**		
Siblings		F / M	**Children**		F / M
		F / M			F / M
		F / M			F / M
		F / M			F / M

Dietary and Lifestyle Habits		
Exercise	How many times do you exercise per week? Never 1x 2x 3x 4x 5x >5x	
	What type of exercise? Strength Building Aerobic/Cardio Flexibility	
Diet	Are you currently dieting? Yes / No	Is it a physician prescribed diet: Yes / No
	Do you have any dietary restrictions?	
	On average, how many meals do you have in a day? 1 2 3 4 5 >5	
Relationships and Sexuality	Are you currently sexually active? Yes / No	
	Describe your sexuality: Heterosexual Homosexual Bisexual	
	List contraceptive method(s) used, if any	
	Do you experience any pain or discomfort during intercourse? Yes / No	

Caffeine	# of cups of the following consumed in a day: Coffee: #_____ Tea: #_____ Cola: #_____	
Alcohol	Do you consume alcohol? Yes / No	If yes, how many drinks/week?
	What type(s) of alcohol do you consume?	
Tobacco	Do you use tobacco? Yes / No	If yes, how many/day?
	What type(s) of tobacco?	How many years?
	Are you exposed to second hand smoke? Yes / No	
Drugs	Do you currently use recreational drugs? Yes / No	
	If yes, which kind(s) and how often?	

Sleep	On average, how many hours of sleep do you get?	
	Do you have trouble falling asleep? Yes / No	
	Do you wake up during the night? Yes / No	If yes, how many times/night?
Energy	On a scale of 1 (lowest) to 10 (highest), rate your energy level	
Stress	What are some stressors in your life?	
Toxins	Are you regularly exposed to any toxins or other hazards? Please specify	

Is there any other important information that you would like me to know?

_____
_____
_____
_____
_____
_____