

Bolton Naturopathic Clinic 64 King Street West, Bolton, ON L7E 1C7 www.boltonnaturopathic.ca Tel. 905-533-5300

Heidi Fritz MA, ND Naturopathic Doctor License # 1565

PATIENT INTAKE FORM

ull Name:First		Last			
Γoday's Date: DD/ MM/ YY	Date of Birth: DD/ MM/ YY	Age:	Gender: M F		
Address:		Apt.:			
City:	Province:	Postal Code:			
Геlephone: Home	Work/ cell				
Email address:					
Would you like to receive our fr	ree bimonthly e-newsletter? Please	e circle: YES	NO		
Occupation:					
	iders (Medical doctors, Chiropract				
1)Name:	Profession:	Tel:			
2)Name:	Profession:	Tel:			
Emergency Contact: Name:	Relation:	Tel:			
How did you hear about us?					
Does your extended health care	plan cover naturopathic medicine?	Circle: YES	NO UNSURE		
Please list in ord	CHIEF CONCERN der of priority, which health areas		nproving		
2					
3					



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MEDICAL HISTORY Please write any medical conditions you have been diagnosed with

	Condition		Date
	MEDICA	TIONS	
Medication & Dose	Condition	Date Taken Since	Adverse Effects
	SUPPLEM		
Supplement & Dose	Condition	Date Taken Since	Adverse Effects
ALLEDOIES, (madiainas, ameiro	contal food other).	· '	
ALLERGIES: (medicines, environm	ientai, 1000, other):		



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FAMILY MEDICAL HISTORY

Please write any medical conditions your family members may have. This includes parents, grandparents, siblings, and children.

Family Member	Condition		
Diet	HEALTH HABITS		
Exercise Habits How many times do you exercise per week?			
What kind of activity?			
Substance Use How many cups of coffee or cola per day? How many alcoholic drinks per week? Do you currently smoke? Y/N Have you smoked in the past? Y/N For how many years?			
Do you use recreational drugs and what kind?			
Energy How many hours of sleep do you get per night?			
What is your energy level, with 1=worst, 10= best?			
What is the biggest source of stress in your life?			



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REVIEW OF SYSTEMS FORM

Please place a check in the Now or Past boxes as applicable for each condition listed. If more than one condition is given, please circle which one you have or have had.

Acne Eczema/psoriasis Hives Excessive hair loss/ growth Itching/rashes Changes in moles (size, colour) EYES Do you wear glasses/ contacts? Floaters Impaired vision/ blurring Glaucoma Cataracts Macular degeneration EARS, NOSE, & THROAT Recurrent ear infections Allergies Impaired hearing Frequent colds/ sore throats Tinnitus/ ringing in ears Hoarseness Ruptured ear drum Bleeding gums/ mouth Excess ear wax Mercury dental fillings Frequent nose bleeds Lumps/ swollen glands in neck Nasal or sinus congestion Thyroid nodules RESPIRATORY Cough Frequent chest infections Pain on breathing Emphysema Shortness of breath Pneumonia Asthma/ wheezing Tuberculosis CARDIOVASCULAR Chest pain/ angina High cholesterol Heart disease Coldness of hands/ legs/ feet Irregular heartbeat Leg pain/ cramps Palpitations Leg swelling/ edema High blood pressure GASTROINTESTINAL Nausea or vomiting Bloating/ Flatulence/ Gas Acid reflux or regurgitation Hemria Indigestion Peptic ulcer Gallbladder stones/ removal Constipation MUSCULOSKELETAL Joint pain/ stiffness Osteopenia/ osteoporosis	Condition	Now	Past	Condition	Now	Past
Hives Excessive hair loss/ growth Itching/ rashes Changes in moles (size, colour) EYES Do you wear glasses/ contacts? Floaters Impaired vision/ blurring Glaucoma Cataracts Macular degeneration EARS, NOSE, & THROAT Recurrent ear infections Allergies Impaired hearing Frequent colds/ sore throats Impaired hearing	SKIN & HAIR					
Itching/ rashes Changes in moles (size, colour)	Acne			Eczema/ psoriasis		
EYES Do you wear glasses/ contacts? Impaired vision/ blurring Cataracts EARS, NOSE, & THROAT Recurrent ear infections Impaired hearing Frequent colds/ sore throats Tinnitus/ ringing in ears Ruptured ear drum Excess ear wax Mercury dental fillings Frequent nose bleeds Nasal or sinus congestion RESPIRATORY Cough Frequent chest infections Pain on breathing Shortness of breath Asthma/ wheezing CARDIOVASCULAR Chest pain/ angina Heart disease Lug pain/ cramps Coldness of hands/ legs/ feet Irregular heartbeat Heart disease Lug pain/ cramps Leg swelling/ edema High blood pressure GASTROINTESTINAL Nausea or vomiting Respiration Respirations Respirations Leg swelling/ Flatulence/ Gas Acid reflux or regurgitation Indigestion Peptic ulcer Gallbladder stones/ removal Blood in stool Musculoskeletal Osteopenia/ osteoporosis				Excessive hair loss/ growth		
Do you wear glasses/ contacts?	Itching/ rashes			Changes in moles (size, colour)		
Impaired vision/ blurring	EYES					
Cataracts Macular degeneration EARS, NOSE, & THROAT Recurrent ear infections Allergies Impaired hearing Frequent colds/ sore throats Tinnitus/ ringing in ears Hoarseness Ruptured ear drum Bleeding gums/ mouth Excess ear wax Mercury dental fillings Frequent nose bleeds Lumps/ swollen glands in neck Nasal or sinus congestion Thyroid nodules RESPIRATORY Cough Frequent chest infections Pain on breathing Emphysema Shortness of breath Pneumonia Asthma/ wheezing Tuberculosis CARDIOVASCULAR Chest pain/ angina High cholesterol Heart disease Coldness of hands/ legs/ feet Irregular heartbeat Leg pain/ cramps Palpitations Leg swelling/ edema High blood pressure Varicose veins GASTROINTESTINAL Nausea or vomiting Bloating/ Flatulence/ Gas Acid reflux or regurgitation Hernia Indigestion Hemorrhoids Peptic ulcer Diarrhea Gallbladder stones/ removal Blood in stool Irritable bowel syndrome MUSCULOSKELETAL Joint pain/ stiffness Osteopenia/ osteoporosis	Do you wear glasses/ contacts?			Floaters		
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Frequent chest infections	Nasal or sinus congestion			Thyroid nodules		
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High blood pressure GASTROINTESTINAL Nausea or vomiting Acid reflux or regurgitation Indigestion Hemorrhoids Peptic ulcer Gallbladder stones/ removal Blood in stool Blood in stool Irritable bowel syndrome MUSCULOSKELETAL Joint pain/ stiffness Varicose veins Bloating/ Flatulence/ Gas Hemorrhoids Diarrhea Constipation Irritable bowel syndrome Osteopenia/ osteoporosis	Irregular heartbeat			Leg pain/ cramps		
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Blood in stool Irritable bowel syndrome MUSCULOSKELETAL Joint pain/ stiffness Osteopenia/ osteoporosis	Peptic ulcer			Diarrhea		
MUSCULOSKELETAL Joint pain/ stiffness Osteopenia/ osteoporosis	Gallbladder stones/ removal			Constipation		
Joint pain/ stiffness Osteopenia/ osteoporosis	Blood in stool			Irritable bowel syndrome		
	Joint pain/ stiffness			Osteopenia/ osteoporosis		
Back pain Sciatica/ nerve pain	Back pain			Sciatica/ nerve pain		
Carpal tunnel syndrome Muscle cramps/ weakness	Carpal tunnel syndrome			Muscle cramps/ weakness		
NEUROLOGICAL 4 of 5	NEUROLOGICAL					



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Headaches/ migraines	Slurred speech	
Fainting/ loss of consciousness	Loss of sensation	
Numbness/ tingling	Seizures	
Paralysis/ weakness	Loss of memory	
MENTAL/ EMOTIONAL		·
Anxiety	Phobias	
Bipolar disorder	Thoughts of suicide	
Depression	Insomnia	
Obsessive compulsive disorder	Excessive stress	
Schizophrenia	Treated for substance abuse	
ENDOCRINE		<u>.</u>
Low iron/ other blood disorder	Excessive thirst or hunger	
Unusual fatigue	Diabetes	
Feeling "wired but tired"	Low blood sugar/ hypoglycemia	
Sensitivity to hot or cold	Thyroid problems	
Hot flushes	Excessive sweating/ urination	
WOMEN'S HEALTH		<u> </u>
Breast lumps/ nipple discharge	Are you sexually active?	
Breast cancer	Do you use birth control?	
Breast pain or tenderness	Birth control pill	
PMS- premenstrual syndrome	Barrier method	
Irregular menstruation	Natural family planning	
Pain with menstruation	Tubal ligation	
Endometriosis	Abnormal PAP test	
Vaginal itching/ discharge	Number of pregnancies	
Yeast/ Candida infections	Number of live births	
Pain on intercourse	Number of miscarriages	
Ovarian cysts	Number of abortions	
Infertility	Age of first period	
Menopausal symptoms	Family history of breast cancer	
Hormone replacement therapy	Other	
MEN'S HEALTH		
BPH – enlarged prostate	Erectile dysfunction	
Difficulty urinating	Penile lesions or discharge	
Prostate cancer	Problems with sperm count	
Testicular pain/ masses	Other fertility problems	
URINARY		
Kidney disease	Frequent urinary tract infections	
Kidney stones	Blood in urine	
Gout	Difficulty urinating	
Incontinence	Pain or burning on urination	

Thank you for taking the time to complete this form.