BOLTON NATUROPATHIC

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

Philip Rouchotas MSc, ND
Naturopathic Doctor
License # 1289

Heidi Fritz MA, ND
Naturopathic Doctor
License # 1565

PATIENT INTAKE FORM

Full Name: ____
First   Last

Today's Date: DD/ MM/ YY   Date of Birth: DD/ MM/ YY   Age: ______   Gender: M F

Address: ______________________________ Apt.:______________

City: ____________________ Province:__________ Postal Code:______________

Telephone: Home ______________ Work/ cell ______________________

Email address: ____

Would you like to receive our free bimonthly e-newsletter? Please circle: YES NO

Occupation: ____

Other Current Health Care Providers (Medical doctors, Chiropractors, etc):

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

CHIEF CONCERNS

Please list in order of priority, which health areas you would like help improving

1. ____

____

2. ____

____

3. ____

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

Condition	Date

MEDICATIONS

Medication & Dose	Condition	Date Taken Since	Adverse Effects

SUPPLEMENTS

Supplement & Dose	Condition	Date Taken Since	Adverse Effects

ALLERGIES: (medicines, environmental, food, 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

HEALTH HABITS

Diet

Please list any dietary restrictions ______________________________

____

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.

Condition	Now	Past	Condition	Now	Past
SKIN & HAIR					
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			Varicose veins		
GASTROINTESTINAL					
Nausea or vomiting			Bloating/ Flatulence/ Gas		
Acid reflux or regurgitation			Hernia		
Indigestion			Hemorrhoids		
Peptic ulcer			Diarrhea		
Gallbladder stones/ removal			Constipation		
Blood in stool			Irritable bowel syndrome		
MUSCULOSKELETAL					
Joint pain/ stiffness			Osteopenia/ osteoporosis		
Back pain			Sciatica/ nerve pain		
Carpal tunnel syndrome			Muscle cramps/ weakness		
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					
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					
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.