Dr. Kelly Brown, N.D.
Naturopathic Doctor

Good n Natural HEALTH FOOD STORE
Quality Vitamins and Supplements · Natural Body Care and Organic Food
www.goodnnatural.ca • Unit A 116 Park Road W, Steinbach, MB R5G 1V6 • ph: 204-326-9565 • fax: 204-326-9836

Naturopathic Medical Intake Form

All information included here will be absolutely confidential. If you have any questions please ask. Thank you.

Name_____ Age _____ M F Today's Date _____

Birthdate (D/M/Y) _____

Home Address _____ Postal Code _____

Occupation _____ Employer _____

Work Phone _____ Home Phone _____ Cell Phone _____

Extended Health Insurance Provider:_____ Group/Plan#_____Contract/ID#_____

Names of Other Healthcare Providers:

Medical Doctors _____ Naturopathic Physician_____

Chiropractor_____ Others _____

How did you hear about our clinic?_____

Your Main Health Concern

Why are you coming to our clinic today?

What are your most important health problems? List in order of importance:

1.

2.

3.

Please list all the vitamin/mineral/herbal supplements you are taking:

Supplement Dose How long you have been taking this supplement?

Please list all current medications:

Medication Dose How long have you been taking this med?

Please list any Past medications:

Your Past Medical History (Please list any major illnesses or surgeries):

Family Medical History

Age, Health Problems, If Deceased, Cause of Death, and Age at Death

Father

Mother

Brother/Sisters

Children

Social History

How many cigarettes do you smoke a day?_____

How much alcohol do you drink per week?_____

Do you take any recreational drugs?_____

Are you exposed to any toxins or chemicals in your home or work (mold, chemicals, etc)?_____

Have you been vaccinated?_____ Which vaccinations?_____

How often do you exercise? What type of exercise do you do? _____

_____

Diet

Are you or have you ever been on a restricted diet? If so, what kind?_____

How much water do you drink/day?_____

How frequently do you move your bowels? _____ per day/week

Please check if the following symptoms are a CURRENT or RECURRING PROBLEM.

General

- ❑ Fatigue
- ❑ Change in appetite
- ❑ Change in thirst
- ❑ Cravings
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Chills or fever
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Allergies
- ❑ Cancer
- ❑ Diabetes

Skin and Hair

- ❑ Dryness
- ❑ Rash
- ❑ Itching
- ❑ Eczema
- ❑ Psoriasis
- ❑ Acne
- ❑ Recent moles
- ❑ Hives/allergic reactions
- ❑ Loss of hair
- ❑ Thinning hair
- ❑ Dandruff
- ❑ Other skin problem(s)

Eyes Ears Nose & Throat

- ❑ Eye pain
- ❑ Eye strain
- ❑ Blurry vision
- ❑ Impaired vision
- ❑ Cataracts
- ❑ Ear aches
- ❑ Ear infections
- ❑ Ringing in ears
- ❑ Vertigo or dizziness
- ❑ Sinus infections
- ❑ Nasal obstruction
- ❑ Post nasal drip
- ❑ Nosebleeds
- ❑ Loss of smell/taste
- ❑ Sores in mouth
- ❑ Mercury fillings
- ❑ Jaw pain or clicks
- ❑ Recurrent sore throat
- ❑ Tonsillitis
- ❑ Enlarged glands
- ❑ Enlarged thyroid
- ❑ Facial pain/tics
- ❑ Headaches

Cardiovascular

- ❑ Chest pain
- ❑ Palpitations
- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Heart attack
- ❑ Congestive heart failure
- ❑ Irregular heartbeat
- ❑ Pacemaker
- ❑ Artificial heart valve
- ❑ Stroke
- ❑ Fainting
- ❑ Varicose veins
- ❑ Deep leg pain
- ❑ Cold hands or feet
- ❑ Swelling of limbs
- ❑ Anemia
- ❑ Easy Bruising

Respiratory

- ❑ Difficulty breathing
- ❑ Shortness of breath
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Emphysema
- ❑ Asthma
- ❑ Wheezing
- ❑ Coughing blood
- ❑ Phlegm in throat

Muscle Bone & Joints

- ❑ Neck pain
- ❑ Back pain
- ❑ Arthritis
- ❑ Bursitis
- ❑ Joint pain or stiffness
- ❑ Artificial joint
- ❑ Muscle pain
- ❑ Muscle weakness

Gastrointestinal

- ❑ Nausea
- ❑ Vomiting
- ❑ Vomiting blood
- ❑ Reflux or heartburn
- ❑ Constant hunger
- ❑ Ulcer
- ❑ Indigestion
- ❑ Abdominal pain or cramping
- ❑ Bloating
- ❑ Gall stones
- ❑ Liver disease
- ❑ Jaundice
- ❑ Intestinal parasites
- ❑ Gas
- ❑ Constipation
- ❑ Diarrhea
- ❑ Chronic laxative use
- ❑ Rectal burning/pain
- ❑ Hemorrhoids
- ❑ Blood in stool

Neurological

- ❑ Anxiety
- ❑ Depression
- ❑ Irritability
- ❑ Emotional problems
- ❑ Loss of balance
- ❑ Poor memory
- ❑ Dizziness
- ❑ Seizures/Epilepsy
- ❑ Concussion
- ❑ Lack of coordination
- ❑ Extremity numbness
- ❑ Extremity tingling
- ❑ Paralysis

Infections

- ❑ Strep throat
- ❑ Mononucleosis
- ❑ Tuberculosis
- ❑ Hepatitis
- ❑ HIV/AIDS
- ❑ Sexually transmitted disease

Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Incontinence
- ❑ Pain on urination
- ❑ Waking at night to urinate
- ❑ Urinary tract infection
- ❑ Blood in urine
- ❑ Kidney stones

Male Reproductive

- ❑ Prostate problem
- ❑ Impotence
- ❑ Sores on genitals
- ❑ Discharge
- ❑ Testicular Mass
- ❑ Testicular pain
- ❑ Infertility/low sperm count
- ❑ Hernia

Female Reproductive

- ❑ Irregular periods
  - ❑ Heavy
  - ❑ Light
  - ❑ Clots
- ❑ Painful periods
- ❑ PMS
- ❑ Sore breasts with menses
- ❑ Infertility
- ❑ Vaginal sores
- ❑ Vaginal discharge

Date of last Pap _____
Irregular?_____
If yes, date?_____
Age of first menses __

Menopausal Y/N

Age of last menses __
_____

Currently pregnant?
Y/N
Currently Breastfeeding?
Y/N

Do you practice
birth control?
Y/N
Type _____

Number of:

- Pregnancies _____
- Abortions _
- Miscarriages_____
- Births _____

Breasts

- ❑ Lumps
- ❑ Tenderness
- ❑ Nipple discharge

Do you do breast self-exams?
Y/N

There are some slight risks to treatment by Naturopathic Medicine. These include but are not limited to

• Potential allergic reaction to supplements or herbs
• Some aggravation of pre-existing symptoms as part of healing when using homeopathic remedies

I understand that the Naturopathic Doctor will answer any questions that I have to the best of their ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to treatment by my naturopath. I understand this consent form to cover the entire course of my treatment. I understand that I am free to withdraw this consent and to discontinue participation in these procedures at any time.

Patient Name: (please print) _____

Signature of Patient or Guardian: _____

Date: _____

Diet Diary

Breakfast							
Lunch							
Dinner							
Snacks							
Notes							