

Dr. Heather Thorpe, N.D

Doctor of Naturopathic Medicine

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ACTIVE BACK TO HEALTH CENTRE
Suite 302 Chinook Professional Building
6455 Macleod Trail SW, Calgary AB T2H 0K9

NEW PATIENT INTAKE FORM

Name: _____
(Last name) (First name) (Middle name)

Age: _____ Gender: Female Male Date of Birth: ____/____/____

Address: _____
(street address) (city) (province) (postal code)

Telephone: Home _____ Work _____ Cell _____

Email: _____

Occupation: _____

How did you hear about our office? _____

Emergency Contact: _____
(name) (relationship) (telephone)

Who is your family physician? _____ Date of last physical exam: _____

PLEASE COMPLETE THE FOLLOWING QUESTIONS

Please list your current health concerns in order of importance:

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

Please list all medications, over the counter medications, vitamins and supplements you are currently taking, the dosage and the main reason for taking them:

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

MEDICAL HISTORY

List all surgeries you have had:

_____ year? _____ purpose? _____
 _____ year? _____ purpose? _____
 _____ year? _____ purpose? _____

Environmental Toxic Exposure

Have you been exposed to any toxic chemicals, solvents, sprays, pesticides, herbicides, heavy metals (lead, mercury, cadmium, arsenic, etc) while at home, work or when traveling? Y N

Do you live near power lines or a refinery? Y N

Do you have mercury dental fillings? Y N

Do you have any surgical implants (medical, cosmetic) Y N

Have you ever had any organ transplants? Y N

Do you have a history of alcohol or drug abuse? Y N

Have you been vaccinated? Y N Have you experienced any adverse reactions to your vaccinations?

Do you have any allergies or sensitivities to any of the following:

Foods? _____

Drugs? _____

Environmental (pollen, dust, mold etc.)? _____

FOOD INTAKE HISTORY

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

Do you have any cravings or aversions (please list)? _____

Do you avoid certain foods? Why? _____

How much coffee, black tea or pop do you drink on a daily basis? _____

Are you satisfied with your current eating habits? _____

GENERAL INFORMATION

Weight _____ lbs Weight one year ago: _____ lbs Max weight _____ lbs Height _____

Current energy level: (Low) 1 2 3 4 5 6 7 8 9 10(high)

When do you have the most energy? _____ Least energy? _____

Current stress level: (Low) 1 2 3 4 5 6 7 8 9 10(high)

FAMILY HISTORY

Please check any of the following conditions that have occurred in your family (parents, grandparents, siblings):

- | | |
|---|---|
| Allergies <input type="checkbox"/> | Heart disease <input type="checkbox"/> |
| Alzheimer's <input type="checkbox"/> | Multiple sclerosis <input type="checkbox"/> |
| Arthritis <input type="checkbox"/> | Mental illness <input type="checkbox"/> |
| Cancer <input type="checkbox"/> | Osteoporosis <input type="checkbox"/> |
| Diabetes <input type="checkbox"/> | Parkinson's <input type="checkbox"/> |
| Eczema <input type="checkbox"/> | Thyroid disease <input type="checkbox"/> |
| High cholesterol <input type="checkbox"/> | other _____ |

HEALTH HISTORY

Which of the following symptoms/conditions are you currently experiencing or have you had in the past? (Check all that apply)

Mental emotional

- Mood swings
- Poor concentration
- Depression
- Anxiety or nervousness
- Memory problems
- Anger

Endocrine

- Thyroid disorder
- Diabetes
- Fatigue
- Heat or cold intolerance
- Sugar sensitivities
- Weight loss/gain

Immune

- Chronic infections
- Slow wound healing
- Chronic swollen glands
- Frequent colds

Skin

- Acne
- Rashes
- Boils
- Eczema, hives

Head

- Headaches
- Head injury
- Migraines

Ears

- Ear aches
- Dizziness
- Impaired hearing
- Ringing in ears

Nose and Sinuses

- Nosebleeds
- Sinus problems
- Seasonal hay fever
- Loss of smell

MEN'S HEALTH

Please indicate if any of the following applies to you:

- Hernia
- Low sex drive
- Impotence
- Testicular mass or pain
- Prostate condition. Year of last prostate exam? _____

LIFESTYLE

- | | | | |
|----------------------------|---|---|------------------|
| Do you exercise? | Y | N | |
| Do you smoke? | Y | N | |
| Do you use drugs? | Y | N | How often? _____ |
| Do you drink alcohol? | Y | N | How often? _____ |
| Do you sleep well? | Y | N | |
| Do you fall asleep easily? | Y | N | |
| Do you feel rested? | Y | N | |

Is there anything else I need to know about you personally, about your health condition, or about the circumstances relating to you or your current health condition(s)? _____

Thank you for taking the time to fill out these forms.