NURTURING HEALTH
Naturopathic Clinic

Dear New Patient,

Thank you for taking the time to fill out the following form. The information you are providing is extremely valuable, in that it allows me to offer the best treatment options possible. Please bring this form to your initial appointment. Please know that the information gathered on this form will be treated in a strictly confidential manner.

What to expect at your first visit:

- Your first visit will be approximately 75 minutes long. During the first visit, I will review and discuss your patient intake form in more detail, answer any questions that you may have, perform any relevant physical exams, and discuss treatment options.
- Some additional testing may be suggested during this visit (these tests are not included in the cost of the initial visit).

What to bring to your first visit:

- All the medications and supplements that you are currently taking
- Any recent blood work, imaging, or test results

Please feel free to call 905-372-2369 if you have any questions or concerns.

I look forward to meeting you!

Yours in Health,

Dr. Kristi Prince, ND, IBCLC
License #2073

Dr. Alison Cockerill,ND
License #3311

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ADULT PATIENT INTAKE FORM

Last name:	First Name:		Middle Name:
Date of Birth (mm/dd/yy):	Age:	Sex: F / M / Other	Occupation:
Contact Information			
Full Address:			City, Province:
Postal Code:	Primary phone number:		Secondary phone number:
Email:		Permission to email: Y / N	
Emergency Contact Information			
Last name:	First Name:		Relationship:
Primary phone number:		Secondary phone number:	
Other Healthcare Providers			
Name: Specialty/Focus: Phone number: Fax: Permission to contact? Y / N	Name: Specialty/Focus: Phone number: Fax: Permission to contact? Y / N		Name: Specialty/Focus: Phone number: Fax: Permission to contact? Y / N
Date of last visit to medical doctor:		Date of last physical exam:	
Have you been treated by a Naturopathic Doctor before?			
If yes, by whom?		Date of last visit to ND:	
How did you hear about this clinic?			
If referred, please state by whom:			

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HEALTH ASSESSMENT QUESTIONNAIRE

Please list your health concerns in order of importance to you:
1.
2.
3.
4.
5.

Personal Medical History			
Height:	Current Weight:	Past Min Weight:	Past Max Weight:
Please list and previously diagnosed medical conditions:			
1.			
2.			
3.			
4.			
Please list any allergies or sensitivities (food/environmental/medications):			
1.			
2.			
3.			
4.			
Please list all hospitalizations, surgeries, and/or major injuries you have experienced:			
Description		Year	Outcome/complications?

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Please list all medications (prescription, over-the-counter) & natural products (vitamins, herbs, oils) currently taking:		
Medication or NHP (please indicate brand if possible):	Dose/quantity per day	Why are you taking this product?

Have you ever experienced any adverse effects or an allergic reaction to any of the above products/therapies?

- ○ No
- ○ Yes, please specify _____

Family Health History		
	Age (or age at death)	**Health Concerns**
Mother		
Father		
Siblings		
Grandparents		

Complete answers to all of the questions are to your benefit for the most effective Naturopathic treatment. This is a confidential record of your medical history and will not be released to any person except when you have authorized permission to do so.

Is there anything important that has not been covered in this questionnaire?

_____
_____
_____
_____