RED CANOE

FAMILY NATUROPATHIC

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Restoring health, removing limitations … *…Respecting the healing power of nature*

Welcome to the Clinic

Following is a thorough intake designed to achieve a comprehensive history. A complete history is a most important tool in formulating a health plan for you. If you come to a question that does not apply or you choose not to answer, just leave it blank and continue with the rest of the intake. If you have any questions please feel free to call the clinic

Please bring to your appointment: **1.**This completed form. **2.** Any remedies (vitamins, minerals, homeopathics, herbs, and drug etc) you are currently taking. **3.** Any relevant test results already completed.

As a large number of patients of this clinic have environmental/chemical sensitivities, the office is a perfume-free zone. We would ask that you refrain from wearing any perfumes on your appointment date.

Your appointment is on_____

Full Name _____ Date of Birth _____ _____ _____ yy mm dd Address_____ City _____ Postal Code_____ Phone# Hm(___)_____Wk(___) _____ Email:_____	Occupation _____ Employer _____ Emergency Contact_____ Relationship _____ Phone Number _____ Marital Status: single married widowed divorced (circle) separated partnership Number of Children: ____ ages: _____ If the patient is a child, give parents names: Mother _____ Father_____
HOW DID YOU LEARN OF OUR OFFICE: Friend Relative Health Care Professional Name: _____	**HAVE YOU HAD PREVIOUS NATUROPATHIC CARE**: if yes, when? _____ with whom? _____

List your primary medical doctor and other health care providers you are seeing (DC, RMT, other):

1.	2.	3.

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Establishing Your Health Goals

Please list your health concerns and chief symptoms in order of decreasing severity, starting with the most important. Please note how long each symptom has been present.

Problem/concern	Onset	Frequency	Severity
1. e.g. Headaches	June 2007	4 times per week	mild/moderate/severe
2.			
3.			
4.			
5.			
6.			
7.			

What diagnosis or explanation has been given to you and by whom?

_____
_____
_____
_____

Before you begin our journey together, I would like to discuss something very important that will have a major impact on your ability to recover and achieve maximum improvement. Many Patients achieve significant improvement while others have become frustrated and failed in their attempt to get well. Naturopathic medicine is much more than eliminating your symptoms – it's about living a life of vibrant health. Any discussion of the correct way to achieve health and stay healthy is: a discussion of how you have lived your life up to this point and how you will live it in the future. Therefore, to help you make significant changes in your present health, I want to ask you a few very important questions. I want you to be honest with yourself and really dig deep inside yourself for the answers.

1. Have you made the decision to change? To do what it takes to get well? **Yes__ No__**

I have read something interesting: "The definition of insanity is to keep doing the same thing and expecting different results". If you keep following the same course of treatment you have been following will you results really change. Have you ever wondered if you are on the right path to achieving optimal health? It may require you taking a different path to reach you destination.

Most people I ask tell me they have made the decision to change. But how many people have truly decided to change? There is a difference between deciding something and having "reasons" to actually do it. When you have made a decision to make a change and you know you reasons, you create an internal power that can propel you to achieving health and wellness. So now I ask: …

2. List up to 5 things that you have been unable to do as a result of your present symptoms. Please be specific. (Use extra pages if necessary)

_____
_____
_____
_____
_____
_____
_____
_____

3. List up to 5 things that you plan to do once you are feeling better. Please be specific. (Use extra pages if necessary)

_____
_____
_____
_____
_____
_____

4. Please check off the following that you would like to achieve with my help:

☐ Have more energy	☐ To feel less sleepy in the afternoon
☐ Sleep better	☐ Lose weight
☐ Have better digestion	☐ Increase my sex drive
☐ Have a better immune system i.e. less colds and coughs	☐ Increase metabolism to burn more fat
☐ Not be dependent on laxatives or stool softeners	☐ I want to improve my memory
☐ Have better muscle tone	☐ I want to be able to be more focused
☐ Be in less pain	☐ I want a better mood
☐ No longer use pain medication	☐ I want to reduce my risk of developing a chronic disease
☐ No longer use allergy medication	☐ I want to detoxify my body
☐ No longer use sleep medication	☐ I want to improve my diet
	☐ I want to clear up my skin

5. Are there any other health goals you want to achieve?

_____
_____
_____
_____
_____

PRESCRIPTION medications you take (or have taken) on a regular basis, including birth control

Name of prescription medication	Dose	Date started	# per day	Side effects, if any. Date stopped

Use the back of this sheet if additional paper is necessary

NON-PRESCRIPTION medications you take (or have taken) on a regular basis, including vitamins &herbs

Name and brand	Dose	Date started	# per day	Side effects, if any. Date stopped

Use the back of this sheet if additional paper is necessary

Have you had all standard vaccinations YES NO

Name of Medication	Type of side-effect/reaction	Age	Year

Please list any medications/immunizations/foods that you stopped because allergic reaction

Are you following any special diets
Other treatments you are currently following (massage, rehab, diets etc)

On a time line please list all surgeries, major injuries, accidents or falls, hospitalizations, and any positive or negative significant events in your life (e.g. marriage, divorce, death of a pet or friend, graduations or other significant miles markers in your life)

Date	Event description and details (chronologic account of persistent, recurrent or significant illness or injuries, surgical procedures, etc.)

Family Genetics - (Please mark any health problem(s) your family has suffered with either now or in the past)

	Father	Mother	Grandmother (paternal)	Grandfather (paternal)	Grandmother (maternal)	Grandfather (maternal)	Other family members (siblings,uncles/aunts, etc)
Present age or age deceased?							
Heart attack							
Stroke							
High blood pressure							
Emphysema							
Arthritis							
RA							
Lupus							
Diabetes							
Parkinson's							
Alzheimer's							
Osteoporosis							
Glaucoma							
Cancer (CA) Colon							
CA Breast							
CA Prostate							
CA Skin							
CA Uterine							
CA other							
Depression							
MS							
Alcohol addiction							
Smoking addiction							
Asthma							
Pneumonia/ Bronchitis							
Obesity							
Headache							
Insomnia							
Cholesterol							
Thyroid problems							
Psychiatric illness							
Other							

Your usual health is: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Number of times per/week you exercise at least 30 min: ☐ 0 ☐ 1-2 ☐ 3-5 ☐ over 5 times/week

Record the number of servings you consume daily of each of the following:

coffee _____ decaf coffee _____ regular tea ____ herbal tea ____ soft drinks ____ milk ____ juice ___ water ____ beer ____ spirits ____ other ____

Have you linked any symptoms with drinking any of them? If so which symptoms?

_____

Do you eat fish? yes no On average, how many days per week? _____ Type(s) of fish eaten (eg. tuna/salmon etc.)? _____

Please list any foods or beverages that do not agree with you (eg. stuffy runny nose, heartburn, bloating, diarrhea, sleepiness, difficulty thinking or concentrating, etc.) or cause allergic reactions

List foods/drinks that are a problem	What problem(s) do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More

(eg. hives, other rashes, shortness of breath, wheezing, anaphylaxis, etc.):

PHYSICAL INFORMATION

Weight now		Ideal weight	
Weight one year ago		Height	
Maximum weight		Date of last physical examination	

List any foods/beverages that you crave or that help you to feel better:

List foods/drinks that you crave	What problem(s), if any, do they give you?	Approximately how often do you eat / drink them?			
		Never	Occasionally	Daily	More

Reactions/Sensitivities/Allergies to natural substances

Are you allergic to pollen, animal dander, dust, mites, or moulds? yes no (please specify) _____
Have you ever had allergy tests yes no

Reactions/Sensitivities/Allergies to Synthetic Substances - Have you ever had symptoms you linked with exposure to any synthetic (man-made) chemical at a level that did not seem to bother most people (eg paints, perfumes, cosmetics, diesel exhaust, tar etc), if yes please explain below

Man-made chemical	Symptoms linked with exposure	Presently affected	In the Past

DENTAL AMALGAMS

How many mercury fillings do you have?		How many gold fillings/caps do you have?	
How many mercury fillings have you replaced?		Do you have any other metal in your mouth?	

SMOKING HISTORY

Do you currently smoke tobacco? yes __ no ___	If yes how many/day:____ For how many years ____
If you smoked previously when did you quit?____□	How many/day _____ For how many years ____

TRAVEL ILLNESSES: Have you ever experienced significant illness when travelling

Illness	Location	Age	Year

STRESSES: Do you currently face or have faced any of the following stresses

	□= yes	Year			Year
Loss of someone close			Divorce		
Illness in someone close			Pregnancy		
Loss of job			Alcohol/Drug addiction		
Change of job			Alcohol/Drug addiction (in someone else)		
Change of workplace			Physical abuse		
A move			Emotional abuse		
Marriage			Sexual abuse		
Separation			Other (please specify)		