PACIFICA
NATUROPATHIC CLINIC

Natural health care for the whole family

Dr. Nina Lange and Dr. Amy Rolfsen, Naturopathic Physicians

Confidential Adult Intake Form

Please fill out these forms as completely as possible.
This is a confidential record of your medical history and the information contained in it will not be released to any person unless you authorize us to do so.

Name:_____ **Date:** _____
Address:_____ **Phone (H):** _____
City/Postal Code: _____ **Phone (B):** _____
Date of Birth: _____ **Age:** _____ **Gender:** _____
Occupation:_____
Marital Status: _____ **Number of children:** _____
Emergency Contact: _____ **Phone:** _____
Medical Doctor: _____ **Phone:** _____
How did you hear about us? _____
Email: _____

☐ **Check here to sign up for Pacifica's seasonal newsletter** - recipes, health tips and clinic news sent 3-4 times each year

Allergies & Emergency: please list any known allergies and emergency information

_____
_____

Main Health Concerns/Goals in order of importance to you

_____
_____
_____
_____
_____

Please list all of your current medications (prescription, herbs, vitamins) & amounts

_____
_____
_____
_____

www.pacificanaturopathic.com
2468 HAYWOOD AVENUE WEST VANCOUVER BC V7V 1Y1
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Past Medical History (please check and date)

- ❑ Cancer
- ❑ High Blood Pressure
- ❑ Heart Disease
- ❑ Strep throat
- ❑ Allergies (drugs, chemicals, foods)
- ❑ Diabetes
- ❑ Seizures/epilepsy
- ❑ Thyroid disease/Goitre
- ❑ Hepatitis
- ❑ Sexually Transmitted Disease
- ❑ Arthritis
- ❑ Depression
- ❑ Asthma
- ❑ Eczema
- ❑ Kidney disease
- ❑ Alcoholism or Drug abuse
- ❑ Chicken Pox
- ❑ Emphysema
- ❑ Parasites
- ❑ Mononucleosis
- ❑ Pneumonia
- ❑ Cold sores
- ❑ Tonsillitis
- ❑ Tuberculosis
- ❑ Eating disorders
- ❑ Prostatitis

Family Medical History

Please indicate family member, circle P for Paternal and M for Maternal side of family

- ❑ Cancer M P
- ❑ Diabetes M P
- ❑ Seizures M P
- ❑ High Blood Pressure M P
- ❑ Heart Disease/Stroke M P
- ❑ Asthma M P
- ❑ Allergies M P
- ❑ Arthritis M P
- ❑ Skin diseases M P
- ❑ Depression M P
- ❑ Tuberculosis M P

Major Injuries and Operations

What major injuries or operations have you had? Date

_____ _____

_____ _____

_____ _____

Vaccinations (please check)

- ❑ DPT (Diptheria, Pertussis, Tetanus)
- ❑ MMR (Measles, Mumps, Rubella)
- ❑ Chicken Pox
- ❑ Polio
- ❑ Other _____
- ❑ Flu Shot
- ❑ Hepatitis A
- ❑ Hepatitis B
- ❑ Hemophilus Influenza B

Did you experience any adverse effects from them? _____

How often have you been treated with antibiotics in your lifetime?

_____

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Please check if you are experiencing the following symptoms or write 'P' beside the box if you have experienced these symptoms in the past..

General

- ❑ Poor appetite
- ❑ Weight gain
- ❑ Weight loss
- ❑ Poor sleep
- ❑ Fatigue
- ❑ Chills and fevers
- ❑ Night sweats
- ❑ Sweat easily
- ❑ Cravings
- ❑ Strong thirst

Skin and Hair

- ❑ Rashes
- ❑ Itching
- ❑ Eczema
- ❑ Acne
- ❑ Loss of hair
- ❑ Dandruff
- ❑ Recent moles
- ❑ Dryness
- ❑ Hives
- ❑ Boils

Eyes Ears Nose Throat

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

Cardiovascular

- ❑ High blood pressure
- ❑ Low blood pressure
- ❑ Irregular heartbeat
- ❑ Dizziness
- ❑ Fainting
- ❑ Chest pain
- ❑ Varicose veins
- ❑ Cold hands or feet
- ❑ Swelling of limbs

Respiratory

- ❑ Difficulty breathing
- ❑ Chronic cough
- ❑ Bronchitis
- ❑ Asthma
- ❑ Coughing blood
- ❑ Throat phlegm
- ❑ Wheezing

Muscle, Bone & Joints

- ❑ Neck pain
- ❑ Back pain
- ❑ Muscle pain
- ❑ Muscle weakness
- ❑ Arthritis
- ❑ Bursitis
- ❑ Other pain

Gastrointestinal

- ❑ Gas or burping
- ❑ Bad breath
- ❑ Constipation
- ❑ Diarrhea
- ❑ Abdominal pain
- ❑ Nausea
- ❑ Vomiting
- ❑ Chronic laxative use
- ❑ Rectal pain
- ❑ Hemorrhoids
- ❑ Blood in stool
- ❑ Constant hunger
- ❑ Bloating
- ❑ Intestinal worms
- ❑ Indigestion
- ❑ Bowel movements/ day:___

Neurological

- ❑ Loss of balance
- ❑ Irritable
- ❑ Poor memory
- ❑ Anxiety
- ❑ Depression
- ❑ Dizziness
- ❑ Lack of coordination
- ❑ Seizures
- ❑ Concussion
- ❑ Numbness of feet
- ❑ Mood swings

Genito-Urinary

- ❑ Frequent urination
- ❑ Urgency to urinate
- ❑ Pain on urination
- ❑ Wake up at night to urinate
- ❑ Incontinence
- ❑ Kidney stones
- ❑ Kidney infection
- ❑ Prostate problem
- ❑ Impotent
- ❑ Sores on genitals
- ❑ Blood in urine

Female

- ❑ Irregular periods
- ❑ Painful periods
- ❑ Vaginal discharge
- ❑ Vaginal sores
- ❑ Sore breasts
- ❑ Abdominal cramps

Length of cycle: _____
Age of first menses ____
Date of last Pap _____

Menopausal Y N
Age of last menses ____

Pregnant Y N
Birth control _____
Number of:

- pregnancies _____
- abortions _____
- miscarriages _____
- births _____

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Diet

Please list any food sensitivities/allergies:

_____

_____

Do you have any dietary restrictions (ie. vegetarian, vegan, religious)?

_____

_____

Please describe a typical day's diet

Breakfast _____

Lunch _____

Dinner _____

Snacks _____

Beverages: *Please indicate how many glasses of each type per day*

Water____ Juice___ Milk____ Coffee ____ Black tea____ Herbal teas ____ Pop ____

Lifestyle

Please indicate if you are currently using

- ❑ Alcohol (# of drinks___/day/week)
- ❑ Tobacco (type and amount _____)
- ❑ Stimulants (type:_____)
- ❑ Recreational drugs
- ❑ Laxatives
- ❑ Diet pills

Describe type and amount of exercise you do per week:

Describe any hobbies/ other recreational activities/ interests:

List any pollutants you are exposed to on a regular basis:

What is your level of stress? (identify any major stressors):

Is there anything else that you feel is important that has not been covered?:

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Consent Form:

Dear Patient

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis and lab work. Therapeutic procedures include: homeopathy, spinal adjustment, botanical medicine, acupuncture, clinical nutrition, lifestyle counselling, intramuscular injection therapy, intravenous vitamin/mineral/nutrient therapy and pharmaceutical medications.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects. I also understand that there is no guarantee or warranty for a specific cure result.

I also understand that if I miss an appointment or cancel on short notice (less than 24 hours), I may be charged a fee for the missed appointment.

Signature x_____ Date x_____

Doctor's Signature x_____ Date x_____

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x_____ Date x_____

Welcome!

Thank you for taking the time to fill out this extensive questionnaire. Your answers will help us decipher what is going on so we can come up with the steps that will lead you to vibrant health!