AURORA
MASSAGE & CHIROPRACTIC
WELLNESS CENTRE INC.

Naturopathic Medicine Intake Form

All information you choose to share with me is kept strictly confidential.

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Sex: M / F

Mailing Address: _____

_____

Phone: (Home) _____ Phone: (Work/Cell) _____

Emergency Contact – Name:_____ Telephone #: _____

Email address: _____
Occupation: _____ Marital status: _____

Medical Doctor: _____ Phone: _____

Other Health Care providers:
1. Name: _____ Phone: _____ Type: _____
2. Name: _____ Phone: _____ Type: _____
3. Name: _____ Phone: _____ Type: _____

How did you find out about our clinic?
_____

Have you ever seen a Naturopathic Doctor before? Yes / No
If so, when was your last visit? _____

Please list in order of priority, areas of your health in which you would like me to help you:

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

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What prescription medications are you currently taking?

1. _____ For How Long? _____
2. _____ For How Long? _____
3. _____ For How Long? _____
4. _____ For How Long? _____
5. _____ For How Long? _____

What supplements (vitamins, minerals, homeopathic, digestive aids, etc.) are you currently taking?

1. _____ For How Long? _____
2. _____ For How Long? _____
3. _____ For How Long? _____
4. _____ For How Long? _____
5. _____ For How Long? _____

What other medications have you taken in the past? For How Long?

_____

What is your current weight? _____
What is your ideal weight? _____
What was your weight one year ago? _____

How much physical exercise do you get per week? _____ hours
What are your favorite modes of exercise? _____

Do you:

Eat regular meals?	Yes	No		
Drink coffee?	Yes	No	Cups per day: _____	
Drink alcohol?	Yes	No	Ounces per week: _____	
Have a lot of stress?		Yes	No	
Use recreational drugs?		Yes	No	Past
Smoke cigarettes/tobacco?		Yes	No	Past

Number of antibiotic prescriptions in the past 10 years: _____
Date of most recent antibiotic prescription: _____

Have you ever had the flu vaccine: Yes No
Date of most recent flu vaccine: _____

Have you ever experienced any adverse reactions to vaccinations in the past? Yes / No
If yes, explain:

_____

_____

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Past health concerns (Injuries, surgeries, hospitalizations, medical conditions, etc):

_____
_____
_____
_____
_____

Current Health Status:

Are any of these conditions a part of your health history? (please check):

Allergies		Hepatitis	
Asthma		High blood pressure/ High cholesterol	
Autoimmune disorder		Psychiatric conditions	
AIDS, HIV		Seizures	
Bleeding disorder		Skin conditions	
Communicable disease		STDs	
Depression		Tuberculosis	
Diabetes		Other:_____	

Family Health History:

Please indicate which family members have any of the following conditions:

Diabetes	Depression
Heart disease	Addictions
High Blood Pressure	Allergies
Cancer	Asthma
Kidney disease	Musculoskeletal/Nervous system
Other:	I do not know my family history:_____

Emotional Climate:

How would you describe your stress level?
At work? _____
At home?_____
With family?_____
Driving/commuting?_____

How well do you feel you are managing your stress?

_____
_____
_____
_____
_____

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Sleep:

How well do you sleep? _____

_____

On average how many hours do you sleep? _____
How many times do you wake per night?_____
Do you wake well rested?_____

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

_____

_____

CHECK ANY OF THE FOLLOWING THAT APPLY TO YOU CURRENTLY, OR IN THE PAST

- ☐ Pneumonia
- ☐ Rheumatic Fever
- ☐ Polio
- ☐ Tuberculosis
- ☐ Whooping Cough
- ☐ Anemia
- ☐ Measles
- ☐ Fibromyalgia
- ☐ Mumps
- ☐ Small Pox
- ☐ Chicken Pox
- ☐ Diabetes
- ☐ Cancer
- ☐ Heart Disease
- ☐ Thyroid Disorders
- ☐ HIV Positive / AIDS
- ☐ Influenza
- ☐ Pleurisy
- ☐ Arthritis
- ☐ Epilepsy
- ☐ Mental Disorder
- ☐ Lumbago
- ☐ Eczema
- ☐ Hepatitis

CHECK CURRENT CONDITIONS WITH "Y" AND THOSE IN THE PAST WITH "P"

MUSCULOSKELETAL
- ☐ Low Back Pain
- ☐ Pain (Where?)
- ☐ Joint pain / stiffness
- ☐ Difficulties walking
- ☐ Difficult chewing / clicking jaw
- ☐ General stiffness

NERVOUS SYSTEM
- ☐ Nervousness
- ☐ Headaches
- ☐ Numbness
- ☐ Cold / Tingling extremities
- ☐ Stress
- ☐ Dizziness
- ☐ Forgetfulness
- ☐ Confusion / Depression
- ☐ Fainting
- ☐ Convulsions

EARS/EYES/NOSE/THROAT
- ☐ Vision problems
- ☐ Dental problems
- ☐ Sore throat
- ☐ Earaches
- ☐ Hearing difficulty
- ☐ Stuffed nose

GASTROINTESTINAL / LIVER / GALLBLADDER
- ☐ Poor / excessive appetite
- ☐ Excessive thirst
- ☐ Frequent nausea
- ☐ Vomiting
- ☐ Diarrhea
- ☐ Constipation
- ☐ Hemorrhoids
- ☐ Liver problems
- ☐ Weight problems
- ☐ Abdominal cramps
- ☐ Gas / Bloating after meals
- ☐ Black / Bloody stools
- ☐ Heartburn
- ☐ Colitis
- ☐ Gallstones

CARDIOVASCULAR
- ☐ Chest pain
- ☐ Blood pressure problems
- ☐ Irregular heartbeat
- ☐ Heart problems

RESPIRATORY
- ☐ Lung problems / Congestion
- ☐ Shortness of breath

FEMALE
- ☐ Menstrual irregularities
- ☐ Menstrual cramping
- ☐ Vaginal pain / infection
- ☐ Breast pain / lumps
- ☐ Breast implants

Are you pregnant?
- ☐ Yes
- ☐ No
- ☐ Not Sure

BIRTH CONTROL
- ☐ Pill
- ☐ IUD
- ☐ Other
- ☐ None

MALE
- ☐ Prostate disorders
- ☐ Sexual concerns/dysfunction

GENITO-URINARY
- ☐ Bladder problems
- ☐ Pain / Excessive urination
- ☐ Kidney Stones/Infections

GENERAL
- ☐ Fatigue
- ☐ Allergies

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Declaration and Consent

Name of Patient: _____ Date: _____

Date of Birth: _____ Age: _____

Address: _____

Phone (Home): _____ (Work/Cell):_____

This is to acknowledge that I have been informed and understand that:

- Any treatment or advice provided to me as a patient of Irena Bergmann is not mutually exclusive from any treatment or advice that I may now be receiving or may in the future receive from another licensed health care provider
- I am at liberty to continue medical care from a medical doctor or other health care provider licensed to practice in Ontario
- Irena Bergmann has not suggested or recommended that I refrain from seeking or following the advice of another licensed health care provider
- I declare that I have received a full and complete explanation of the treatment and/or services that I will receive and hereby authorize and consent to treatment by Irena Bergmann
- Payment is to be made in cash, cheque, Visa or Master Card only at the end of the appointment
- I am aware that no part of my treatment is covered by OHIP and that I am solely responsible for payment
- ***24 hours cancellation notice is required or I will be charged the full fee for missed appointments***

Signature: _____

Print Name: _____

_____
Signature of Parent (if patient is under 18 years of age)

Print Name: