KAWARTHA THERAPEUTIC CENTRE

Naturopathic Medicine Intake Form

Please take a moment to fill out the intake form before your visit. All information is kept completely confidential.

CONTACT INFORMATION

First Name _____Last Name _____Date _____

Occupation _____ Date of birth: _____(MM/DD/YYYY)

Address:_____

_____

E-mail Address:_____ Tel: (_____)_____

Please list all healthcare practitioners who are managing your care (please include your family doctor):

Name:_____	Name:_____	Name:_____
Specialty:_____	Specialty:_____	Specialty:_____
Date of last visit:	Date of last visit:	Date of last visit:
_____	_____	_____

When was your last blood work done?

- ☐ within last 3 months
- ☐ within last 3-6 months
- ☐ within last 1-2 years
- ☐ 2 years +

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Please list all conditions/diagnoses that you've received or have been treated for:

1._____ Date: _____ 4._____ Date: _____

2. _____ Date: _____ 5. _____Date: _____

3. _____ Date: _____ 6. _____Date: _____

Please list all past serious injuries, and/or hospitalizations:

1._____Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

5. _____ Date: _____

History of past infections (including childhood.) Examples of infection include: strep throat, mononucleosis, ear infections, bronchitis, urinary tract infections, yeast infections, STIs, etc.

1._____Date: _____

2. _____ Date: _____

3. _____ Date: _____

4. _____ Date: _____

5. _____ Date: _____

Have you ever had a traumatic brain injury, concussion, or injury where you hit your head?

Yes □ No □ Maybe □

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In your lifetime, how many courses of antibiotics have you received?

0-4 □ 5-9 □ 10-14 □ 15+ □

Please list all <u>current</u> medications (prescription and over-the-counter) and natural health products (herbs, vitamins, etc.). Include dosage and duration of use.

1. _____
2. _____
3. _____
4. _____
5. _____
6. _____
7. _____
8. _____
9. _____
10. _____

Please list allergies or dietary restrictions (intolerance, vegetarian, vegan, religious, etc.)? .

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

FAMILY MEDICAL HISTORY

Write <u>P</u> if either parent had/has condition. Write <u>S</u> for sibling and <u>G</u> for grandparent:

Cardiovascular (high blood pressure, high cholesterol, heart failure, heart attack or stroke) _____

Mental health (depression, anxiety, bipolar, OCD, etc.) _____

Endocrine (Thyroid, diabetes, obesity, etc.) _____

Cancer _____

Chronic pain (Fibromyalgia, post-surgical, etc.) _____

Arthritis _____

continued on next page...

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Immune (Allergies, sinusitis, ear infections, etc.) _____

Hormonal (Menopausal symptoms, endometriosis, PCOS, etc.) _____

Respiratory (COPD, asthma, etc.) _____

Skin (eczema, psoriasis, rosacea) _____

Bowel (IBS, crohn's disease, ulcerative colitis, etc.) _____

Other _____

HEALTH GOALS

How satisfied are you with your current state of health? (0= totally dissatisfied, 10= ultimate satisfaction)

_____

What are your health concerns and goals, in order of importance to you:

1. _____

2. _____

3. _____

Have you ever consulted a Naturopathic doctor before? Yes □ No □

How did you hear about Dr. Jackson?

- ☐ Referral from medical doctor or another health care practitioner
- ☐ Social media. ex. facebook, instagram, etc.
- ☐ I'm an existing patient at Kawartha Therapeutic Centre (KTC)
- ☐ KTC website
- ☐ Dr. Jackson's website
- ☐ I attended your talk/workshop
- ☐ From a friend or family member
- ☐ Other _____

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What are the biggest obstacles that are preventing you from achieving your health goals? (Ex. energy, motivation, young kids at home, influence from family/friends, time spent at work, misinformation, cooking skills, etc.)

How willing are you to make dietary and lifestyle changes? (0=I don't want to change anything about my current lifestyle and diet, 5=Well, that depends, 10=I will do anything)

Are there any particular modalities that you would like to have incorporated into your treatment plan?

- ☐ Acupuncture
- ☐ Cupping
- ☐ Herbal medicine
- ☐ Nutritional supplementation
- ☐ No preference

Thank you for taking the time to fill out this intake form.