vitallife integrative medicine

Today's Date (Date, Month, Year): _____

Practitioner (Please select):

- ☐ Cheryl Cooper, ND
- ☐ Erin Whyte, RMT
- ☐ Nathalie Breton, CNP, ROHP
- ☐ Priscilla Corcoran, CC Hypnotist
- ☐ Katrina Ostafichuk, ND
- ☐ Robbin Zrudlo, Reconnection Practitioner
- ☐ Aloke De, MBBS

Name: _____

Address: _____

City: _____ Province: _____ Postal Code: _____

Home Phone #: _____

Mobile Phone #: _____

Office Phone #: _____

Preferred contact method? Home #: _____ Mobile #: _____ Work #: _____ Email: _____

Email Address: _____

Sex: M _____ F _____ Birthdate (Date, Month, Year): _____ _____ _____

How did you find out about us?

- ☐ Vitallife web site
- ☐ Internet Search (ie Google)
- ☐ Sign/Walking By
- ☐ Advertisement
- ☐ Other Internet site:
- ☐ Other health care provider:
- ☐ Family/friend:
- ☐ **Other:** _____

Office Use

- ☐ Status to Active
- ☐ Practitioner Selected
- ☐ Cancellation Policy in Notes
- ☐ Referral Method

Adult Naturopathic Intake Form – PATIENT HISTORY

Occupation:_____ Employer: _____
Status: Single: ___ Married: ___ Divorced: ___ Living with partner: ___ Widowed: ___ Other: ___
Do you have children? Yes: ___ No: ___
If yes, list age and sex: _____, _____, _____
Emergency Contact: _____
(last name) (first name)
_____
(day phone) (evening phone)
When was your last physical exam? _____
Did you have bloodwork or other tests done at that time? _____
Who are your other health care providers?

_____	_____	_____
(name)	(phone)	(fax)
_____	_____	_____
(name)	(phone)	(fax)
_____	_____	_____
(name)	(phone)	(fax)

Please list your health concerns in order of importance to you.

Concern	Since	Concern	Since
1.		5.	
2.		6.	
3.		7.	
4.		8.	

Please indicate any treatment or testing you have had or are currently receiving for the above concerns.

GENERAL HEALTH HISTORY

Height: _____ Current Weight: _____ Weight changes in the past year? _____
Maximum weight? _____ When? _____
Minimum weight? _____ When? _____
What do you feel is the most comfortable weight for you? _____
When is the last time you were at this weight? _____
How many colds, flus, and/or other acute illnesses have you had in the past year? _____
What were they, and when did you have them?

Type	When

How would you rate your enegery on a scale of 1 – 10, with 10 being the most energy? /10
Is there a time of day when your energy is better? _____ Worse? _____
How many hours of sleep do you get per night on average? _____
Do you have trouble getting to sleep? Yes / No / Sometimes
If so, why? _____
Do you ever take anything to help you sleep? Yes / No / Sometimes
If yes, what? _____

Do you wake up during the night? Yes / No / Sometimes
Why do you wake up? _____
Are you able to get back to sleep right away? Yes / No / Sometimes
If not, what do you do? _____
Do you feel rested on waking? Yes / No / Sometimes
Do you take naps? Yes / No / Sometimes
Do you remember your dreams? Yes / No
If yes, describe the nature of your dreams: _____

MEDICAL HISTORY

Please check the conditions you have had or currently have.

Alcoholism		Depression		Ulcers	
Allergies		Diabetes		Kidney Disease	
Anemia		Drug use		Liver Disease/Jaundice	
Anxiety		Eczema		Overweight	
Asthma		Emphysema		Pneumonia	
Arthritis		Headaches/Migraine		Rheumatism	
Bleeding		Heart Murmur		Tuberculosis	
Cancer		High Blood Pressure		Other	
Candida		Hyperthyroid			
Colitis/Crohn's		Hypothyroid			

Please list any major trauma, stresses, injury, or accident you have experienced in your life.

Trauma	Year	Long-term effects

Please list any surgical procedures you have undergone.

Procedure	Year	Complications

Please list other forms of treatment that you have used and describe their effectiveness.

Form of Treatment	Effectiveness

ALLERGIES AND SENSITIVIES

Please list any allergies, sensitivities and/or intolerances that you are aware of.

Medications	Food	Environmental/Chemical

Are you aware that you have ever been exposed to toxic substances such as chemicals pesticides, herbicides, solvents, or sprays, at home or at work? Yes / No

If yes, please give details: _____

Are you aware that you have ever been exposed to heavy metals such as lead, mercury, arsenic or cadmium? Yes / No

If yes, please give details: _____

Please answer yes or no to the following questions. If you answered yes, please explain.

Have you ever had to lower the regular dose of prescription medication, over-the counter medication or herbal supplementation because you were too sensitive to the regular dose? Yes / No

Which medications? _____

Do you avoid caffeine in the afternoon or altogether because it keeps you up at night? Yes / No

Do you smell odours others cannot? Yes / No

If so, which odours? _____

Do you have a sudden onset of symptoms (headaches, rashes, nausea, fatigue, shortness of breath, etc) when exposed to chemicals, mold, dust, pollen, or other environmental allergens? Yes / No

If so, which ones? _____

MEDICATIONS / SUPPLEMENTS

Please list all present medications and supplements including drugs, herbs, vitamins, minerals, homeopathics, bach flower remedies and Chinese herbal remedies.

Name of Supplement/Medication (Include Brand Names)	Amount Taking and How Often	For what?	How long for?

Which of the following have you used / currently use? Please include amount, frequency and length of use; use **P** to indicate past use and **C** for current use.

Tobacco		Alcohol	
Recreational drugs		Steroids	
Cortisone		Laxatives	
Sedatives		Pain Relievers	
Coffee		Anti-Inflammatories	
Diet Pills		Other	

Have you ever taken antibiotics? Yes / No

If yes, what kind and for what? _____

_____

FAMILY HISTORY

Please indicate any health conditions for the following family members:

	Mother	Father	Siblings	Grandparents	Other blood relatives
Cancer					
Heart disease					
Arthritis					
TB					
Diabetes					
Asthma					
Allergies					
Food sensitivities					
Digestive issues					
Celiac disease					
Crohn's/colitis					
Thyroid					
Autoimmune					
Kidney disease					
Depression/anxiety					
Anemia					
Stroke					
Seizures					
High blood pressure					
Other					

FOOD AND DIGESTION

How much water do you drink daily? _____

What other beverages do you drink, and how much? _____

Do you prefer your beverages hot, cold, or neutral: _____

How often do you have a bowel movement? _____

Do you have any issues with digestion (i.e. heartburn, gas, bloating, indigestion)? _____

List the primary foods included in your diet for:

Breakfast	
Lunch	
Dinner	
Snacks	

Are there any foods you exclude from your diet? Why? _____

_____

Are there any foods that you crave specifically? (chocolate, sweets, salty, sour, rich/fatty, breads, spicy) _____

_____

_____

WORK AND LIFESTYLE

Do you enjoy your work? Yes / No

What do you like and/or dislike about your work? _____

_____

Are you currently in a relationship? Yes / No

For how long? _____

If so, are you happy with your relationship? Yes / No

Do you have a supportive family or friends who are there when you need them? Yes / No

Does your family live near enough to you that you can see them regularly? Yes / No

Do you exercise? Yes / No

If yes, what kind and how often? _____

_____

What do you do in your spare time? _____

_____

What are your interests and hobbies? _____

How often do you enjoy them? _____

What do you do for yourself? _____

SEXUALITY

Now	Past		Now	Past	
		Excessive sexual desire			Lack of sexual desire
		Sexually transmitted disease			Multiple partners
		Pain during intercourse			Sexual dysfunction
		Uncomfortable with sexuality			

Are you currently sexually active? Yes / No

What type of birth control and/or sexual protection do you use? _____

_____

Do you use sexual protection consistently? Yes / No

Sexual preference: Heterosexual _____

Homosexual _____

Bisexual _____

MALE REPRODUCTIVE SYSTEM (if applicable)

Now	Past		Now	Past	
		Prostate problems			Sores on penis
		Difficulty getting an erection			Discharge from penis
		Painful erection			Premature ejaculation
		Swelling/lumps in testicles			Difficulty with ejaculation
		Testicular pain			Infertility
		Other sexual difficulties			

Date of last prostate exam?_____

FEMALE REPRODUCTIVE SYSTEM (if applicable)

Now	Past		Now	Past	
		Breast pain/tenderness			Painful intercourse
		Breast lumps			Vaginal discharge
		Nipple discharge			Vaginal dryness
		Pelvic Pain			Vaginal itching/burning
		PMS			Genital eruptions
		Spotting/bleeding between periods			Excessive menstruation
		Never/seldom orgasmic			Absent menstruation
		Birth Control Pills			Abnormal PAP test
		Pain before menses			Pain during menses
		Pain after menses			Clots during menses
		Moodiness			Fluid retention
		Sexual difficulties			Endometriosis
		Cysts			

Average number of days period lasts for _____
Average number of days of cycle? _____
Date of last period? _____
Number of pregnancies _____
Number of live births _____
Number of miscarriages _____
Number of terminated pregnancies
Have you had any difficulty conceiving? Yes / No / N/A
Date of last gynecological exam/PAP test? _____
Date of last breast exam? _____ Mammogram? _____ Thermography? _____
Regular breast self-exams? Yes / No

ADDITIONAL

Is there any other information relevant to your health that has not been addressed?

_____
_____
_____
_____

Use the back of this page to describe yourself in words or pictures.

Thank you for taking the time to complete these forms.