ST. ALBERT NATUROPATHIC CLINIC

New Patient Intake

Name:_____ **Date**:_____
Date of birth: M:_____ D:_____Y:_____ **Sex**: M F
Email:_____ (To receive test results and newsletter)

Address:_____ Phone: _____h
City:_____ _____w
Postal Code: _____ _____c

May we leave messages relating to your visits? Y N

Emergency Contact- Name: _____ Phone: _____

Where did you learn of the St. Albert Naturopathic Clinic? _____

Other health care providers (Medical Dr, Chiropractor):

1._____ 2. _____
_____ _____
_____ _____
(____)_____ (____)_____

Please list your health concerns, in order of importance:

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

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates:

_____

_____

Do you have any allergies (medicines, environmental, etc.)?

_____

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Please list all current medications (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.):

_____

_____

Please list past prescription medications (used within last two years):

_____

_____

Do you frequently use any of the following? (circle)

Aspirin Laxatives Antacids Diet pills Birth control pills/implants/injections

Alcohol—how much/day or week _____
Tobacco—form and amount/day _____
Caffeine—form and amount/day _____
Non-Prescription Drugs—what and how often_____

Do you get regular screening tests done by another doctor? (Pap, blood tests, etc.)? Y N

Diet

Do you have any food allergies, intolerances or diet restrictions (vegetarian)? Please list.

_____

Do you crave any specific foods (sweets, salty, breads, etc)?

_____

Family History

Indicate if a close relative (grandparent, parent, child, sibling) has had any of the following: ☐ I don't know my family medical history

Allergies		Asthma		Cancer	
Diabetes		High Blood Pressure		Heart Disease	
Digestive Disorders		Depression		Other Mental Illness	
Drug or Alcohol Abuse		Kidney Disease		Obesity	
Eczema		Psoriasis		Osteoporosis	

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Environment

Occupation: _____

Do you exercise regularly? Y N

Are you exposed to significant tobacco smoke (work, home, etc.)? Y N

Are you frequently exposed to animals (work, pets, etc.)? Y N

Are you regularly exposed to toxins or other hazards (work, home, hobbies, etc.)?

Please describe: _____

How would you describe the emotional climate of your home? _____

Do you consider yourself stressed? Y N

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

_____

_____

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