Holistic Clinic
Integrative Health Care

2211 Riverside Drive • Ottawa, ON • K1H 7X5
Voice: 613.521.5355 • Fax: 613.521.4189
www.holisticclinic.ca

ADULT INTAKE

Date: _____

Name: _____ DOB (yy/mm/dd): _____

Occupation: _____ # of years: _____

Marital Status: _____ # of children: _____

Current Health Concerns

What health concerns brought you here today (in order of importance to you?)

1. _____
2. _____
3. _____

Known allergies: _____

Family Doctor: _____

Medications: _____

_____

_____

Supplements: _____

_____

_____

Lifestyle (circle all that apply)

Tobacco Alcohol Coffee Water Regular exercise Stress environmental toxins

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Personal Health History

Please check all that apply to you.

allergies ☐
Alcoholism ☐
anemia ☐
anxiety ☐
arthritis ☐
asthma ☐
cancer ☐
celiac disease ☐
chicken pox ☐
childhood illnesses ☐
depression ☐
diabetes ☐
heart disease ☐
high cholesterol ☐
high blood pressure ☐
infectious disease ☐
measles ☐
mumps ☐
migraines ☐
rheumatic fever ☐
seizures ☐
stroke ☐
thyroid disease ☐
tuberculosis ☐
whooping cough ☐

Hospitalizations/surgeries: _____

_____

Family Health History

Please check all that apply for immediate family (i.e. grandparents, parents, siblings).

alcoholism ☐
allergies/hay fever ☐
anemia ☐
anxiety ☐
asthma ☐
arthritis ☐
autoimmune disorders ☐
bleeding problems ☐
cancer ☐
depression ☐
diabetes ☐
seizures ☐
epilepsy ☐
gout ☐
heart disease ☐
high blood pressure ☐
high cholesterol ☐
infectious disease ☐
kidney problems ☐
migraines ☐
obesity ☐
psychiatric illness ☐
stroke ☐
substance abuse ☐
thyroid disease ☐
tuberculosis ☐

Is there anything else your Naturopathic Doctor should be aware of? _____

_____

_____

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General Information Form

Date: _____

Name		**Date of Birth (mm/dd/yy)**	
Gender	☐ **M** ☐**F**	**Age**	
Address		**City**	
Province		**Postal Code**	
Telephone	**Home:**	**Work:**	**Mobile:**
E-mail:			
Emergency Contact		**Relationship**	
Telephone	**Home:**	**Work:**	**Mobile:**

1. May we leave a voicemail at these numbers: ☐ Yes ☐ No

2. Do you have a family doctor: ☐ Yes ☐ No

   Name of MD: _____ Telephone: _____

3. Other Health Care Professionals We Need to Be Aware of:

   Name: _____ Telephone: _____

4. If you have extended health care insurance, please provide the name of the insurance company.

   _____

5. How did you hear about the Holistic Clinic? Circle one:
   Family/Friend Health Practitioner Newspaper Community Event/Seminar
   Online/Internet

   Name of Referral: _____

6. Would you like to be added to our e-mail list to be informed of natural health updates, recipes, seminars or other events presented by the Holistic Clinic? We will not share your e-mail information with any outside parties. ☐ Yes ☐ No