Holistic Clinic
Sports and Occupational Injury Management

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

Adult New Patient Intake Forms

I would like to welcome you to the Naturopathic Medical Services offered at the Holistic Clinic. My goal is to help you understand factors that may be affecting your health and to develop strategies to improve your health and well-being. Please complete these forms as thoroughly as possible, as your responses help in assisting recommendations to support your wellness goals. Please bring the completed forms with you for your first visit.

Please also bring the following in to your first visit (if you have it):

- Any recent bloodwork (within the past year)
    - If you do not have a copy we can request a copy from the lab company, hospital or your MD.
- Any supplements, medications or remedies that you are currently taking. Please include:
    - Brand
    - Amount you are taking
    - When you take it
    - Why you are taking it.

I look forward to our meeting.

Sincerely,

Dr. Maureen MacDonald ND 1758

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Date: _____

Name:_____ **Mr. Mrs. Ms. Miss** **Age:** _____

Date of Birth: _____/_____/_____ (MM/DD/YYYY)

Marital Status: Single Married Partner Separated Divorced Widowed

Live with: Self/Alone Spouse Partner Children Friend Other

Address:

_____

Street & Apt/House Number City Province Postal Code

Contact Information

Home Phone: _____ Cell: _____

Business Phone: _____ E-Mail: _____

Emergency Contact: _____ Phone: _____
Name & Relationship

How did you hear about us?: _____

Would you like to receive e-mail newsletters? Yes No

_____

Health Care Providers

Primary Health Care Physician: _____ Phone: _____

Practise Name/Location of Primary Care Physician: _____

Health Card # _____(for the purpose of Release of Records)

Are you under the care of a medical specialist/alternative care providers? Yes No

Name: _____ Specialty: _____ Phone: _____

Name: _____ Specialty: _____ Phone: _____

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Allergies/Sensitivities: Are you allergic/sensitive to medications, herbs, foods, animals, or any other substance? (Please circle)

No Known Drug Allergies Penicillin Hydromorphone Antibiotics NSAIDS

Aspirin Sulfa Drugs Insulin Chemotherapeutics Immunotherapy

Bees/Wasps/Insects

Dairy Wheat/gluten Soy Nuts: _____

Citrus Grains Other: _____

Other Allergies/Sensitivities: _____

What happens to you during a reaction: _____

What makes it better? _____

How often do these reactions occur? _____

Have you ever been hospitalized or needed to go to the emergency room from a reaction: YES NO

Current Health Concerns:

Chief Health Concerns/What Brought You Here?:

1. _____

2. _____

3. _____

What expectations do you have from THIS VISIT to the clinic?

_____

_____

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What LONG TERM expectations do you have working with a Naturopathic Doctor?

What is your present level of commitment to address any underlying causes of your symptoms to your lifestyle? (Please rate from 1 to 10 with 10 being high importance)

1 2 3 4 5 6 7 8 9 10

Factors needing to be addressed/considered for the development of your treatment plan?

Example: shift worker

Behaviour and Lifestyle

Things you do that you'd consider supportive of your health/well-being:

Areas of your health/well-being that you'd like to work on/think are NOT supportive?:

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What is your SOCIAL SUPPORT NETWORK like? (Please circle)

Great Good Could Be Better I'm On My Own

Who are the key members of your social support network? _____

What is your diet like now? (Please describe a typical day)

_____

_____

_____

_____

Is this different from how you have eaten in the past? If yes, when did you make the changes & what did you change from?

_____

_____

Alcohol: Drinks per week: _____ Beverage Preference: _____

Drinks per day: _____ Habit Description: _____

Water: Glasses per day: _____ Filtered Reverse Osmosis Bottled

Tap Distilled Alkalinized

Soda Water Tonic

Juice: Yes No If yes – type and frequency: _____

Coffee: Yes No # per day: _____ How do you take your coffee? Milk Sugar Black Other

Tea: Yes No # per day: _____ How do you take your tea? Milk Sugar Other As Is

Other Regularly Consumed Beverages: (ie pop) _____

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Smoking/Tobacco: Never In the past Presently How much? ____ How long? ____

Recreational Drugs: Never In the past Presently How much? ____ How long? ____

Current Medications: (Prescriptions & Over The Counter)

Medication	Reason for Drug	Dose	Duration

Any medications used for more than 5 years of your life, which you have not mentioned? For example, oral contraceptives, IUD, antidepressants, antianxiety medication, etc.: Yes No

If yes: _____

Number of times on Antibiotics in the PAST 10 YEARS & reason: _____

Current Supplements:

Supplements & Brand	Reason for Taking	Dose	Duration of Use

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Past Medical History (Please Circle All That Apply):

Allergies	Childhood Illnesses	Migraines	Auto Immune Disorders
Alcoholism	Depression	Rheumatic Fever	Osteoporosis
Anemia	Diabetes	Seizures	
Anxiety	Heart Disease	Stroke	
Arthritis	High Cholesterol	Thyroid Disease	
Asthma	High Blood Pressure	Tuberculosis	
Cancer	Infectious Diseases	Whooping Cough	
Celiac Disease	Measles	Kidney Problems	
Skin disorders	Chicken Pox/Mumps	Obesity	

Hospitalizations/Surgeries: _____

Do you ever get any of the following? (please circle all that apply)

Cankers	Cold Sores	Easy Bruising	Ringing in the Ears
Frequent Heartburn	Diarrhea	Constipation	Post-Nasal Drip
Bronchitis	Frequent colds/flus		

Muscle Cramps and Spasms (what parts are most regularly affected): _____

Sleep/Waking Schedule:

Bedtime: _____ Waking: _____ Snooze Button: _____

Insomnia: Hard Time Falling Asleep: Yes/No Hard Time Staying Asleep: Yes/No

Do you get up to urinate? Yes/No How often?: _____ What Time?: _____

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Bowel Movements: Frequency _____(per day/per week)

Quality (please circle): Easy to pass: Yes/No _____ Blood/Mucous: Yes/No _____

Please Circle any of the following that you take:

Antacids (Rolaids/TUMS) Cough/cold medicine Flu Vaccine

Pain Relievers: Aspirin Tylenol Advil Naproxen

Diet pills

Sleeping Pills: _____

Antihistamines: Benadryl Reactine Aerius Claritin Other: _____

Cortisone: Cream Pills

Yeast Infection Medications _____

Oral Contraceptives/Hormone Replacement Therapy: _____

Is there anything else Dr. Maureen MacDonald ND needs to be aware of?

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Family History
Please be as detailed as possible. Please include/describe parents, siblings, aunts, uncles and grandparents:

General (Please circle):

Allergies	Childhood Illnesses	Migraines	Auto Immune Diseases
Alcoholism	Depression	Rheumatic Fever	Obesity
Anemia	Diabetes	Seizures	
Anxiety	Heart Disease	Stroke	
Arthritis	High Cholesterol	Thyroid Disease	
Asthma	High Blood Pressure	Tuberculosis	
Cancer	Infectious Diseases	Whooping Cough	
Celiac Disease	Kidney Problems		

Family Member	Current Age	Age at Death	Health Problem or Cause of Death
Mother			
Maternal Grandmother			
Maternal Grandfather			
Father			
Paternal Grandmother			
Paternal Grandfather			
Siblings			
Children			