Interior
Naturopathic & Wellness

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306 – 153 Seymour Street, Kamloops, BC, V2C 2C7
InteriorNaturopathic.ca

Care Card # (PHN): _____ Date: _____

First Name: _____ Last Name:_____

Gender: _____ Date of Birth (DD/MM/YY): _____ Age:_____

Address:_____

City:_____ Province: _____ Postal Code: _____

Home PH: _____ Work PH: _____ Ext:_____ Cell PH: _____

Email address:_____

If needed, can the clinic contact you via email (circle): YES NO

Occupation:_____

Please circle: Single Common-Law Married Divorced Separated Widowed

Emergency contact Name: _____ PH:_____

Relationship:_____

How did you hear about Interior Naturopathic & Wellness: _____

**Current Health Concerns:**

1._____

2. _____

3._____

4._____

5. _____

Medications (Prescription and Non Prescription):

_____

Allergies (Medication, Food, Environmental):

_____

Supplements (Vitamins, Minerals, Herbs, etc.):

_____

Do you or anyone in your family suffer from a Glucose-6-Phosphate Dehydrogenase (G6PD) Deficiency?

_____

**Past Medical History:**

| | | |
|---|---|---|
| ☐Heart Disease | ☐Asthma | ☐Easy bruising/bleeding |
| ☐High Blood Pressure | ☐Hepatitis | ☐Thyroid Disease |
| ☐Elevated Cholesterol | ☐Seizures | ☐Depression/Anxiety |
| ☐Diabetes | ☐Drug/Alcohol Abuse | ☐Colitis/Crohn's Disease |

Past Procedures/Surgeries/Hospitalizations: (Description & Date):

_____

_____

_____

**Family Medical History** (Blood Relatives, NOT including yourself):

| | Which Relative and Age of Onset? | Doctors notes |
|---|---|---|
| ☐Addiction | | |
| ☐Allergies | | |
| ☐Arthritis | | |
| ☐Asthma | | |
| ☐Cancer | | |
| ☐Depression/Anxiety | | |
| ☐Diabetes | | |
| ☐Dementia | | |
| ☐Gout | | |
| ☐Hearing Loss | | |
| ☐Heart Attack | | |
| ☐Hepatitis | | |
| ☐High Blood Pressure | | |
| ☐High Cholesterol | | |
| ☐Kidney Disease | | |
| ☐Multiple Sclerosis | | |
| ☐Obesity | | |
| ☐Osteoporosis | | |
| ☐ Seizures/Epilepsy | | |
| ☐Stroke | | |
| ☐Thyroid Disease | | |

Please check if you have OR are currently experiencing any of these symptoms:

**General:**

| | | |
|---|---|---|
| ☐Weight-loss | ☐Chills | ☐Excessive sweating |
| ☐Weight-gain | ☐Fatigue | ☐Excessive thirst |
| ☐Fevers | ☐Cold hands or feet | ☐Bleed or bruise easily |

**Hair, Skin and Nails:**

| | | |
|---|---|---|
| ☐ Eczema/Psoriasis | ☐ Changes in moles | ☐ Loss of hair |
| ☐ Itching | ☐ Easy bruising | ☐ Dandruff |
| ☐ Dryness | ☐ Ulcers | |
| ☐ Rashes | ☐ Changes in nails (cracked or brittle) | |

**Head/Eyes/Ears/Nose/Throat:**

| | | |
|---|---|---|
| ☐Headaches | ☐Corrected vision | ☐Mouth sores |
| ☐Neck pain | ☐Glaucoma | ☐Bleeding gums |
| ☐Head trauma | ☐Earaches | ☐Toothaches/jaw pain |
| ☐Eye pain/strain | ☐Ringing in ears | ☐Mercury fillings #_____ |
| ☐Blurred vision | ☐Facial pain | ☐Hoarseness of voice |
| ☐Dry eyes | ☐Sinus congestion/infection | ☐Recurrent sore throats |
| ☐Floaters | ☐Nose bleeds | |
| ☐Cataracts | ☐Post-nasal drip | |

**Heart and Circulation:**

| | | |
|---|---|---|
| ☐Heart palpitations/Arrhythmias | ☐Heart Disease | ☐Blood clots in legs or lungs |
| ☐High Blood pressure | ☐Heart Attack | ☐Swelling in feet or legs |
| ☐Low blood pressure | ☐Stroke | ☐Varicose veins |
| ☐Heart murmurs | ☐Pacemaker | ☐Peripheral artery disease |

**Lungs:**

| | | |
|---|---|---|
| ☐Difficulty breathing | ☐Wheezing | ☐Pneumonia |
| ☐Chest pain or tightness | ☐Asthma | ☐Tuberculosis |
| ☐Persistent cough | ☐Bronchitis | |
| ☐Coughing up blood | ☐Emphysema | |

**Digestion:**

| | | |
|---|---|---|
| ☐Ingestion/Heartburn | ☐Vomiting | ☐Colitis/Crohn's disease |
| ☐Gas/Bloating | ☐Difficult or painful swallowing | ☐Hernia |
| ☐Diarrhea | ☐Stomach ulcers | ☐Hemorrhoids |
| ☐Constipation | ☐Abdominal pain | ☐Anal Fissures |
| ☐Poor/Excessive appetite | ☐Blood in stool | ☐Gallbladder disease |
| ☐Bad breath | ☐Mucus in stool | ☐Parasitic infection |
| ☐Nausea | ☐Undigested food in stool | ☐Liver disease |

**Genito-Urinary:**

| | | |
|---|---|---|
| ☐Frequent Urination | ☐Incontinence | ☐Kidney stones |
| ☐Pain with urination | ☐Urinary tract infections | ☐Blood in urine |
| ☐Frequent urination at night | ☐Kidney disease | |

**Muscoloskeletal:**

| | | |
|---|---|---|
| ☐Back pain | ☐Joint swelling | ☐Osteoarthritis |
| ☐Neck pain | ☐Muscle weakness | ☐Rheumatoid Arthritis |
| ☐Joint pain/sprain | ☐Bone pain | ☐Osteoporosis |

**Neurological/Psychological:**

| | | |
|---|---|---|
| ☐Numbness | ☐Paralysis or weakness | ☐Sudden mood changes |
| ☐Dizziness | ☐Epilepsy/Seizures/Convulsions | ☐Eating Disorder |
| ☐Loss of Balance | ☐Stress | ☐Chemical Dependency |
| ☐Problems with walking | ☐Depression | ☐Alcohol Dependency |
| ☐Problems with speaking | ☐Anxiety | ☐Suicidal thoughts |
| ☐Problems with coordination | ☐Difficulty concentrating | |

**Women's Health:** ☐check if the following section is not applicable to you

| | |
|---|---|
| First day of last period: | Number of days between periods: |
| Number of days of menstrual flow: | |
| PMS Symptoms (check all that apply):<br>☐None ☐Pain with menstruation ☐Breast tenderness ☐Bloating ☐Acne ☐Mood swings<br>☐Fatigue ☐Headache ☐Other: _____ | |
| Birth Control use? If so, which type and for how long?: | |
| # Pregnancies:_____ # Births:_____ # Miscarriages:_____ # Abortions:_____ | |
| Date of last PAP exam: | Any abnormal PAP exams?: |
| Ovarian cysts?: | Uterine fibroids?: |
| Menopause?: How many months since your last period?: | |
| Menopause Symptoms (check all that apply):<br>☐ Hot Flashes ☐ Night Sweats ☐ Vaginal dryness ☐ Vaginal atrophy<br>☐ Difficulty concentrating ☐ Difficulty sleeping ☐Depression/Mood changes<br>☐ Decreased libido ☐ Urinary incontinence | |
| Hysterectomy?: | |
| Have you ever had a mammogram?: If so: Normal/Abnormal | |
| Are you sexually active?: | Concerns about sexually transmitted infections?: |

**Men's Health:** ☐check if the following section is not applicable to you

| | Yes | No | Details |
|---|---|---|---|
| Testicular Pain/Swelling? | | | |
| Impotence/Sexual difficulties? | | | |
| Prostatitis/Prostate concerns? | | | |
| Sexually active? | | | |
| Concerns about sexually transmitted infections? | | | |

**Lifestyle and Social History:**

| **Habits:** | **Yes** | **No** | **Details** |
|---|---|---|---|
| Tobacco usage? | | | How much per week?: |
| Do you consume alcohol? | | | Which type?: How drinks per week?: |
| Recreational drug use?: | | | Which type:? How much per week?: |
| Caffeine use?: | | | Which type?: How much per week?: |
| Do you exercise?: | | | How often per week?: |
| **Social:** | **Yes** | **No** | **Details** |
| Are you currently in a relationship? | | | |
| Are you happy in your relationship? | | | |
| Do you have a social support network? | | | |
| **Lifestyle:** | **Yes** | **No** | **Details** |
| Do you enjoy your work? | | | |
| Do you feel stressed? | | | Level (circle): Low Medium High |
| Source of stress? | | | (circle): work family money other: |
| What do you do to relieve stress? | | | |

**Sleep:**

| | Yes | No | Details |
|---|---|---|---|
| Problems falling asleep? | | | |
| Problems staying asleep? | | | |
| Wake up feeling rested? | | | # hours sleep per night?: |
| Do you dream? | | | |

**Diet:**

| | Details |
|---|---|
| Do you follow a particular diet? | |
| Known food allergies/intolerances? | |
| What is your typical breakfast? | |
| What is your typical lunch? | |
| What is your typical dinner? | |
| How much water do you drink per day? | |
| What is your current weight? | |
| What was your weight one year ago? | |
| What is your height? | |

Is there anything else about your health history we should know about?

_____

_____

_____

_____

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

We look forward to working with you on your healing journey!