Interior
Naturopathic & Wellness

P: 250.374.1122
754 Seymour Street, Kamloops, BC V2C 2H3
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!