

# Integrative Health Institute

46 Sherbourne St. 2<sup>nd</sup> Floor  
Toronto, ON M5A2P7  
P: 416.260.6038  
F: 416.260.9799

## Naturopathic/Medical/Nutrition Intake Form

Please complete the following form in order to provide us with the background information we require to ensure you receive comprehensive care. It should take 15-20 minutes.

### Contact Information:

Name	_____	Occupation	_____
Gender (circle)	Male      Female	Employer	_____
Date of Birth	_____	Work Phone #	(    )
E-mail Address	_____	Emergency Contact	_____
Home Phone #	(    )	Emergency Contact #	(    )
Cell	(    )	Contact Relationship	_____
Home Address	_____	OHIP Number	_____

YES    NO    Can we send you our seasonal newsletter and monthly calendar of events via email. Your email address will not be shared.

How did you hear about the Integrative Health Institute? (If another person, please provide name)

### Care Co-ordination:

Medical Doctor	_____	Specialist	_____
Medical Doctor #	(    )	Specialist #	(    )
Medical Doctor Address	_____	Specialist Address	_____
Email	_____	Email	_____
Dentist	_____	Specialist	_____
Dentist #	(    )	Specialist #	(    )
Dentist Address	_____	Specialist Address	_____
Email	_____	Email	_____

### Please List any other Medical Providers:

Type of Medical Provider	Name	Phone #	Address

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Health Priorities / Chief Concerns:

List your main health concerns (or reasons for visiting the clinic) in order of importance

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

Medical History:

How would you describe your general state of health? (circle one)    excellent    good    fair    poor

**Medical conditions:** Please indicate any serious illnesses, conditions, or reasons for hospitalizations

Medical Condition/ Hospitalization	Date of Diagnosis/ Diagnosed by whom	Is the condition still present	Symptoms

**Allergies or Food sensitivities:** Please indicate any allergies and/or serious food sensitivities

Allergy/Sensitivity	Severity of reactions

**Medications/Supplements:** Please list all current medications/supplements

Medication/Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

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**Past Medications/Supplements:** Please list all past medications/supplements in the last 5 years.

Medication/Supplement	Dose (if known)/ Length of Use	Prescribing Physician	Condition it is treating

Have you taken anti-biotics within the last 5 years (circle one)? YES NO  
 How many times have you taken anti-biotics within the last 5 years \_\_\_\_\_  
 Were you frequently given anti-biotics as a child? \_\_\_\_\_

**Vaccinations:** Please indicate which vaccinations you have received.

Vaccination against:	Circle One	Age	Side Effects / Hospital Admittance
Measles, Mumps, Rubella (MMR)	Yes No		
Diphtheria, Pertussis, Tetanus (DPT)	Yes No		
Haemophilus Influenza B (Hib)	Yes No		
Chicken Pox (Varicella Zoster)	Yes No		
Rabies	Yes No		
Hepatitis A	Yes No		
Hepatitis B	Yes No		
Tetanus	Yes No		
Polio	Yes No		
Flu	Yes No		
Other:			

**Do you use/have any of the following?**

Substance	Circle One	How often/ How much/ What brand/type
Alcohol	Yes No	
Cigarettes	Yes No	
Recreations Drugs	Yes No	
Aspirin	Yes No	
Laxatives	Yes No	
Ant-acids	Yes No	
Diet Pills	Yes No	
Coffee	Yes No	
Black Tea	Yes No	
Green Tea	Yes No	
Birth control pill	Yes No	
Birth control implants	Yes No	
Birth control injections	Yes No	
Metal implants	Yes No	
Mercury Fillings	Yes No	How many?
Resin fillings	Yes No	How many
Other	Yes No	

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**Screening Tests:** Please indicate which of the following screening tests do you receive (if known)

Test	Circle One	How often
PAP Test (women)	Yes No Never	
Breast exam	Yes No Never	
Mammogram	Yes No Never	
DEXA scan	Yes No Never	
Digital rectal exam (men)	Yes No Never	
PSA test (men)	Yes No Never	
Cholesterol	Yes No Never	
Blood glucose	Yes No Never	
CBC (complete blood count)	Yes No Never	
Other	Yes No Never	
Other	Yes No Never	

## Female:

Are you currently or could you be pregnant: Y I N    How many weeks: \_\_\_\_\_  
 Have you ever been pregnant? Y I N    How many times: \_\_\_\_\_    How many vaginal births: \_\_\_\_\_    C-Sections: \_\_\_\_\_  
 How old were you when you had your first period: \_\_\_\_\_    Have your periods been regular: \_\_\_\_\_  
 Have you taken/used (circle all that apply): **The birth control pill**    **The patch**    **An IUD**    **Depo Provera injections**    **Other:** \_\_\_\_\_

Are you currently (circle one): **Pre-menopausal**    **Transitioning through menopause**    **Post-menopausal**  
 Have you/are you, taking HRT: Y I N    How long: \_\_\_\_\_

## Family History:

Illness	Circle One	Family Member	Complications / Severity
Allergies	Yes No		
Asthma	Yes No		
Diabetes	Yes No		
Heart Disease	Yes No		
Cancer	Yes No		
Depression	Yes No		
Other mental illness	Yes No		
Kidney disease	Yes No		
Infertility	Yes No		
Post-partum depression	Yes No		
High Blood pressure	Yes No		
Other	Yes No		
Family History Unknown	Yes No		

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## Naturopathic/Medical/Nutrition Intake Form

### Lifestyle

Do you identify as: straight homosexual bi-sexual trans-gendered other: \_\_\_\_\_

Do you have a strong emotional support network: Y I N Who: \_\_\_\_\_

Have you experienced any major trauma or loss in the past 5 years? \_\_\_\_\_

Have you experienced any other trauma or loss in your life? \_\_\_\_\_

How would you currently rate your level of stress at this time? **Minimal Average Considerable Unbearable**

What are the major causes of stress in your life at this time: (circle all that apply): **financial career personal marriage/relationship health family spiritual other (please elaborate):** \_\_\_\_\_

How does your stress manifest itself: \_\_\_\_\_

What type of coping mechanism to you employ to manage your stress? \_\_\_\_\_

What do you do for exercise/movement? (Indicate type, frequency and time of day): \_\_\_\_\_

How many hours per night do you sleep: \_\_\_\_\_ nap: \_\_\_\_\_ Do you wake rested in the morning: Y I N

What is your occupation: \_\_\_\_\_ Do you enjoy your work: Y I N I Sometimes

How many hours per day do you spend on the following: Driving \_\_\_\_\_ Watching TV \_\_\_\_\_ Reading \_\_\_\_\_ In front of a computer \_\_\_\_\_ Work \_\_\_\_\_

When was your last vacation: \_\_\_\_\_ Do you actively participate in a spiritual discipline (church, synagogue, meditation, etc...) Y I N

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### Dietary Habits

What time of day do you eat the following: Breakfast: \_\_\_\_\_ Lunch: \_\_\_\_\_ Dinner: \_\_\_\_\_ Snacks: \_\_\_\_\_

Do you consume the following (circle all that apply and indicate frequency): Fresh Vegetables: \_\_\_\_\_ Fresh Fruit: \_\_\_\_\_

Cold-water Fish: \_\_\_\_\_ Tuna: \_\_\_\_\_ canned goods: \_\_\_\_\_ Pop: \_\_\_\_\_ Milk: \_\_\_\_\_ Coffee: \_\_\_\_\_ Water: \_\_\_\_\_

Juice: \_\_\_\_\_ Processed Foods: \_\_\_\_\_ Microwavable meals: \_\_\_\_\_ Red meat: \_\_\_\_\_ Cheese: \_\_\_\_\_ Chocolate: \_\_\_\_\_

Aspartame: \_\_\_\_\_ Deli meats: \_\_\_\_\_ Fast Food: \_\_\_\_\_ Margarine: \_\_\_\_\_

Do you crave (circle all that apply): Sugar Chocolate Salt Crunchy foods other: \_\_\_\_\_

Please provide examples of the following:

Breakfast: \_\_\_\_\_

Snack: \_\_\_\_\_

Lunch: \_\_\_\_\_

Snack: \_\_\_\_\_

Dinner: \_\_\_\_\_

Do you have regular bowel movements: Y I N Do you have to strain for a bowel movement: Y I N Do you regularly have loose stools: Y I N Do you associate digestive difficulties with any particular foods: Y I N Which foods: \_\_\_\_\_

How many bowel movements do you have per day? \_\_\_\_\_

Naturopathic/Medical Intake Form

Review of Systems

Please list conditions or concerns that involve the following systems:

SKIN (eg. eczema, psoriasis, hives, rashes)

LUNGS (eg. cough, asthma, wheezing)

HEAD (eg. headaches)

GASTROINTESTINAL (eg. vomiting, swallowing, diarrhea, constipation)

EYES (eg. itching, pain, infection, corrective lenses)

URINARY (eg. pain, increased frequency, blood)

EARS (eg. wax, discharge, hearing impairment)

MALE (eg. hernias, pain or masses in scrotum/testes)

NOSE (eg. sinus problems, pain, nose bleeds)

FEMALE (eg. urgency, menstruation/menarche, discharge, pain or masses in ovaries/uterus)

MOUTH (eg. difficult dentition, cavities, loss of taste, problems swallowing)

MUSCLE AND SKELETON (eg. joint pain, stiffness, weakness, back pain, fractures)

NECK (eg. stiffness, tenderness, hoarseness, tonsillitis, swelling)

NEUROLOGICAL (eg. seizures, paralysis, clumsiness, memory, vision changes, speech problems, sensation alteration)

HEART (eg. rheumatic fever, murmurs, chest pain)

Additional Information

If there is any other relevant information pertaining to your health that was not covered in this intake please state it below or on the back of the form: