
208A 33123 1st Ave, Mission, BC, V2V 1G5

Full Name:_____ Date:_____

Preferred First Name:_____

Name of parent or guardian if under age 18:_____

Date of Birth:_____ Sex: M___ F___

Occupation:_____

Full Address:_____

_____

Email:_____

Phone: home:_____

mobile:_____

work:_____

Preferred contact number for reminder/follow up calls: home__ mobile__ work__

**Emergency contact name**:_____

Phone:_____ Relationship:_____

**Name of Medical Doctor**:_____

Address:_____

Phone:_____ Date of last visit:_____

How did you hear about us?_____

Were you referred by someone? If yes, whom?_____

WELLNESS CENTRE
208A 33123 1st Ave, Mission, BC, V2V 1G5

Name:_____

Age:_____ Height:_____ Weight:_____

**What are your health concerns in order of importance?**

1.

2.

3.

**Please list all prescription medications currently taken *including dose, frequency, and duration of use***

1.

2.

3.

**Please list all over the counter medications you are taking (ie. aspirin, tylenol, antacids, etc)**

_____

_____

**Please list all supplements and herbal remedies you are currently taking i*ncluding dose and frequency***

_____

_____

_____

Do you have any allergies? (medications, foods, environmental)

_____

_____

Approximately how many courses of antibiotics have you taken over the last 5 years?

_____

_____

Do you smoke or have you smoked in the past? If so, **how much and for how long**?

_____

_____

Do you currently, or have you in the past used recreational drugs? If yes, what type and how often?

_____
_____

Please list any serious illnesses, hospitalizations or surgeries, along with approximate dates

_____
_____

Please list significant health concerns of family members (including siblings, parents, aunts, uncles, and grandparents)

_____
_____

Do you have any dietary restrictions we should know about? (ie. vegetarian, vegan, religious, lactose intolerance, celiac disease, etc.)

_____
_____

**Please describe your typical daily diet:**

Breakfast:_____

Lunch:_____

Dinner:_____

Snacks:_____

Beverages:_____

Do you exercise? If so, please indicate type, frequency, and duration.

_____
_____

What level of stress do you feel you are currently experiencing?

minimal average significant unbearable

What are the main stressors in your life?

_____
_____

**Circle 'Y' if you are currently experiencing the symptom. Circle 'P' if you have experienced the symptom in the past. If needed, write comments/explanations.**

**Skin**

| | | | |
|---|---|---|---|
| Itching | Y | P | |
| Dryness | Y | P | |
| Hives | Y | P | |
| Eczema | Y | P | |

| | | | |
|---|---|---|---|
| Psoriasis | Y | P | |
| Boils | Y | P | |
| Acne | Y | P | |
| Rosacea | Y | P | |
| Skin cancer | Y | P | |
| Weak nails | Y | P | |
| Nail fungus | Y | P | |

**Head**

| | | | |
|---|---|---|---|
| Headaches | Y | P | |
| Migraines | Y | P | |
| Head injury/trauma | Y | P | |
| Dizziness | Y | P | |
| Loss of hair | Y | P | |

**Eyes**

| | | | |
|---|---|---|---|
| Eye pain | Y | P | |
| Tearing | Y | P | |
| Dryness | Y | P | |
| Floaters | Y | P | |
| Double vision | Y | P | |
| Blurred vision | Y | P | |
| Cataracts | Y | P | |
| Glaucoma | Y | P | |
| Bothered by the sun | Y | P | |
| Blind spot | Y | P | |

**Ears**

| | | | |
|---|---|---|---|
| Hearing impairment | Y | P | |
| Earache | Y | P | |
| Discharge | Y | P | |

| | | | |
|---|---|---|---|
| Infection | Y | P | |
| Tinnitis (ringing) | Y | P | |

**Nose**

| | | | |
|---|---|---|---|
| Frequent cold or flu | Y | P | |
| Nose bleeds | Y | P | |
| Stuffiness/congestion | Y | P | |
| Hay fever | Y | P | |
| Sinus infections | Y | P | |

**Mouth and Throat**

| | | | |
|---|---|---|---|
| Frequent sore throats | Y | P | |
| Sore tongue/mouth | Y | P | |
| Difficulty swallowing | Y | P | |
| Gum disease/gingivitis | Y | P | |
| Hoarse voice | Y | P | |
| Loss of taste | Y | P | |
| Dry mouth | Y | P | |

**Neck**

| | | | |
|---|---|---|---|
| Pain or stiffness | Y | P | |
| Enlarged thyroid | Y | P | |
| Enlarged lymph glands | Y | P | |

**Cardiovascular**

| | | | |
|---|---|---|---|
| Heart disease | Y | P | |
| High blood pressure | Y | P | |
| High cholesterol | Y | P | |
| Chest pain | Y | P | |
| Swelling in ankles/feet | Y | P | |
| Palpitations/fluttering | Y | P | |

**Respiratory**

| | | | |
|---|---|---|---|
| Cough | Y | P | |
| Sputum | Y | P | |
| Wheezing | Y | P | |
| Asthma | Y | P | |
| Bronchitis | Y | P | |
| Shortness of breath | Y | P | |
| Pain with breathing | Y | P | |
| Pressure or tightness in chest | Y | P | |

**Digestive**

| | | | |
|---|---|---|---|
| Heartburn or reflux | Y | P | |
| Changes in thirst/appetite | Y | P | |
| Nausea/vomiting | Y | P | |
| Bowel movements - **how often?** | | | |
| Blood in stool | Y | P | |
| Belching | Y | P | |
| Gas/bloating | Y | P | |
| Ulcer | Y | P | |
| Indigestion | Y | P | |
| Diarrhea | Y | P | |
| Constipation | Y | P | |
| Hemorrhoids | Y | P | |

**Male**

| | | | |
|---|---|---|---|
| Testicular mass | Y | P | |
| Sexual difficulties | Y | P | |
| Venereal disease | Y | P | |
| Discharge or sores | Y | P | |

**Female**

| | | | |
|---|---|---|---|
| Age menses began | | | |
| Average length of cycle (ie. 28 days) | | | |
| Average number of days of bleeding | | | |
| Bleeding between periods | Y | P | |
| Irregular cycles | Y | P | |
| Pain during intercourse | Y | P | |
| Painful menses | Y | P | |
| PMS | Y | P | |
| Excessive flow | Y | P | |
| Breast tenderness | Y | P | |
| Breast lumps/cysts/discharge | Y | P | |
| Last menstrual period | Date: | | |
| Last PAP test | Date: | | |
| History of abnormal PAP test? | **Y** | **N** | |
| Abnormal discharge | Y | P | |
| Vaginal itching | Y | P | |
| Difficulty conceiving | Y | P | |
| Birth control | Y | P | Type:<br>Duration of use: |
| Number of pregnancies | | | |
| Number of live births | | | |
| Number of miscarriages | | | |
| Number of abortions | | | |
| Sexual difficulties | Y | P | |
| Venereal disease | Y | P | |

**Urinary**

| | | | |
|---|---|---|---|
| Pain with urination | Y | P | |
| Increased frequency | Y | P | |
| Inability to hold urine | Y | P | |

| | | | |
|---|---|---|---|
| Frequent bladder infections | Y | P | |
| Kidney stones | Y | P | |
| Blood in urine | Y | P | |

**Musculoskeletal**

| | | | |
|---|---|---|---|
| Joint pain and/or stiffness | Y | P | |
| Arthritis | Y | P | |
| Muscle cramps or spasms | Y | P | |
| Back pain | Y | P | |

**Peripheral Vascular**

| | | | |
|---|---|---|---|
| Deep leg pain | Y | P | |
| Cold hands/feet | Y | P | |
| Varicose veins | Y | P | |
| Extremity numbness or tingling | Y | P | |

**Neurological**

| | | | |
|---|---|---|---|
| Fainting | Y | P | |
| Seizures | Y | P | |
| Memory loss | Y | P | |
| Loss of balance | Y | P | |
| Involuntary movement | Y | P | |

**Endocrine**

| | | | |
|---|---|---|---|
| Heat or cold intolerance | Y | P | |
| Thyroid abnormalities | Y | P | |
| Lack of sweating | Y | P | |
| Excessive thirst or urination | Y | P | |
| Diabetes type I or II | Y | P | |
| Hypoglycemia | Y | P | |
| Hormone therapy | Y | P | |

**Blood & Lymphatic**

| | | | |
|---|---|---|---|
| Anemia | Y | P | |
| Easy bruising | Y | P | |
| Lymph node swelling | Y | P | |

**Emotional**

| | | | |
|---|---|---|---|
| Depression | Y | P | |
| Mood swings | Y | P | |
| Anxiety or nervousness | Y | P | |
| Mental illness | Y | P | |
| Alcohol or drug abuse | Y | P | |
| Emotional eating | Y | P | |
| Eating disorder | Y | P | |
| Insomnia | Y | P | |

**Thank you for completing our intake form. This is a confidential medical record and will be kept in the office. We will not release this information to any third party unless you have authorized us to do so.**

evoke
WELLNESS CENTRE
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**Informed Consent**

Printed name _____

As a patient of this clinic I have read the information and understand that the form of medical care is based on naturopathic and other supportive principles and practices. I recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including the possibility of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising, or injury from venipuncture or acupuncture, and muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

_____ _____
Signature of patient (or guardian if under age 18) Date

_____
Name of guardian if under age 18

_____
Witness