Dr. Amanda Guthrie
Naturopathic Doctor

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I care. I listen.

Please bring this fully completed form to your first appointment

New Patient Intake Form

Today's Date:
First Name:
Last Name:
Full address:
Phone *(Please indicate with an * the best way to contact you)*
Home: Work/Cell:
May we leave phone messages pertaining to your visits?
Email address:

Date of Birth: Year	Month	Day	Age:	Gender (please specify):	
Status: Single	Live-in Partner	Married	Separated	Divorced	Widowed
# of Dependents:	Names/Ages of children:				
Who referred you to our office?					
Have you been treated by a Naturopathic Doctor before?	When?				

Name of your Medical Doctor: Phone:
Address:
Date of last visit to Medical Doctor: Date of last physical exam:
Do you have regular screening tests done by another doctor (physical exam, blood tests, etc)?
Name(s) and phone number(s) of other healthcare practitioners you receive treatment from:

Emergency contact (Name and Relationship):
Home Phone: Work/Cell phone:

Health Concerns
What is your primary health concern?
How long have you had this condition? Since (date):
Name of physician who made the diagnosis:
When was the diagnosis made?
What specialist(s) have you seen?
How have you treated this condition until now?

What else would you like to see changed in your health?
Please list all other health concerns in order of importance to you and indicate how these conditions have been treated.

How would you rate your current state of health? Excellent Good Fair Poor

Medical History

(Please circle all illnesses you have experienced)

Acne	Circulation problems	Headaches	Migraine headaches	Thyroid disease
Alcoholism	Diabetes	Heart disease	Mononucleosis Muscle	Tuberculosis
Allergies	Dizziness	Herpes (cold sores)	Numbness / paralysis	Ulcers
Anemia	Drug dependency	High blood pressure	Osteoporosis	Urinary Tract Infection
Arthritis	Ear infections	HIV/AIDS	Pneumonia	Warts
Asthma	Eating disorder	Hives	Prostate disease	Wilson's Disease
Autoimmune disease	Eczema	Kidney disease	Psoriasis	Other:
Back pain or sciatica	Epilepsy	Liver disease	Sexual abuse	
Boils, Impetigo	Fainting	Low blood sugar	Shingles	
Bronchitis	Gallbladder disease	Meningitis	Sinusitis	
Cancer	Gout	Mental Illness	Stroke	

Gastrointestinal Problems:

Abdominal pain/cramps	Constipation	Gas or belching	Mucous in stool	Rectal pain
Anal itching	Diarrhea	Heartburn/acid reflux	Nausea	Ulcer
Appendicitis	Difficulty swallowing	Hemorrhoids	Poor appetite	Undigested food in stool
Bad breath	Excessive appetite	Hernia	Rectal bleeding	Vomiting
Bloating	Excessive thirst	Indigestion	Rectal incontinence	Vomiting blood
Black tarry stool	Food poisoning	Intestinal parasites	Other:	

Emotional Traumas:

Depression	Grief	Major disappointment	Panic attack	Period of stress
Anxiety	Severe phobia	Severe shock	Other:	

Please list all past hospitalizations and surgeries, including when and why they occurred, and any complications:

What medications are you currently taking? *Please indicate the name, the dosage and the date you began taking it.*

Are you pregnant, or is there any chance that you could be pregnant now? Are you currently lactating?

Are you currently taking birth control pills?

How many times, approximately, have you been treated with antibiotics?	How long ago was your last course of antibiotics?
What vitamins or other natural health products are you currently taking? *Please indicate the name, the brand, dosage, and date you began taking it.*	

Family Medical History

(Please circle and indicate their familial relationship to you)

Alcohol/Drug abuse	Allergies	Autoimmune disease	Cancer: type(s)	Diabetes
Eating disorder	Heart Disease	High Blood Pressure	Mental Illness	Obesity / Overweight

Additional Health History

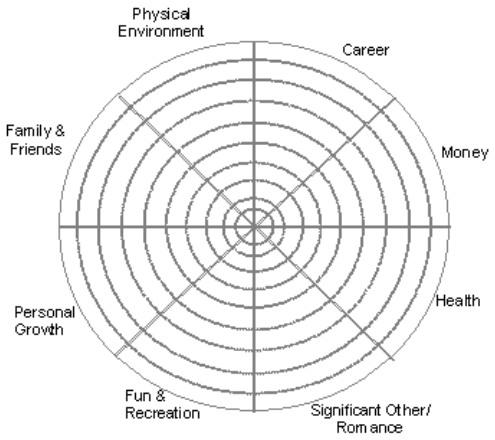
Do you have any known environmental sensitivities? *(Please list)*
Are you regularly exposed to tobacco smoke or other environmental toxins at home or work? *(Please list)*

Diet (*please circle*):	Non Vegetarian	Vegetarian	Vegan	Other:
Please provide examples of foods you typically eat:				
Breakfast				
Lunch				
Dinner				
Snacks				
Beverages				
Are there any foods and/or food groups that you avoid eating? Why?				
How many bowel movements do you have per day or week?				
How much water do you drink per day?		How much coffee, tea or cola per day?		
How much alcohol per week? Which types?		If you smoke, how many packs per day?		
If you use recreational drugs, how often and which types?				
Do you exercise? If so, how often and what form(s) of exercise do you do?				
What is your current weight?		Height?		
Have you lost or gained any weight in the past year (if so, how much)?				
How many hours of sleep do you get per night?		Do you have difficulty falling asleep?		
Do you wake up during the night? If yes, how often?		Do you feel refreshed in the morning?		
On a scale of 1-10, with 10 being the highest, please rate your average **energy** level:				
On a scale of 1-10, with 10 being the highest, please rate your average **stress** level:				
How would you describe the emotional climate of your home?				
What is your occupation?		How many hours do you work per week?		
What do you love to do?				

Wheel of Balance

Wellness is a balance of many factors. Using the circle, shade your level of satisfaction in each area as it relates to you.

For example, if you are 60% satisfied in your career, shade the first six levels of the career slice.
Do the same for each area, starting from the center point radiating outward.



Spiritual or Religious Background

Are you an active participant in a faith? Yes / No

Do you have any dietary restrictions that you adhere to as part of your faith?

Which, if any, spiritual practices do you incorporate into your life? *(Please circle)*

Fasting	Journaling	Meditation	Prayer	Other:

Context of Care and Health Goals

Why did you choose to come to this clinic?

What do you know about our approach?

What expectations do you have from your *first visit* to our clinic?

What *long term* expectations do you have from working with our clinic?

What expectations do you have of me personally as your health care provider?

What does being healthy mean to you? (ex. physical wellness, longevity, energy, peace of mind, quality of life, relationships)

Treating illness and maintaining health does not occur overnight and it *does* require commitment to making lifestyle changes and following treatment protocols. How would you describe your level of commitment to making healthy lifestyle changes at this time, on a scale of 1-10, with 0 being not committed and 10 being fully committed?

What obstacles do you see or feel exist to your achieving your health goals?

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviours or lifestyle habits do you currently engage in regularly that you believe are self-destructive?

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making?

Is there anything else you would like to mention that you feel is important to your health?

Thank you for taking the time to fill out this intake form. It will help greatly in my study of your present health concerns and in developing a treatment plan that is personalized specifically for you.