Dr. Zar
Naturopathic Doctor

Patient Intake Form

Please take time to fill out the following form. It provides a basis for further questions during your visit and helps properly assess your situation. All information is for office use only and will be kept confidential.

General:
Date of visit: _____

Full Name: _____
Date of Birth: _____ Age: _____ Gender: male female

Complete Address: _____
City: _____ Postal Code: _____
Tel. No.: Home: _____ Work:_____ Cell: _____
Email Address: _____
Can we send you emails, newsletters, information on promotions? _____
Preferences for communication: email phone

Occupation: _____ Full-time or Part-time? _____
Marital Status: single married separated divorced other: _____
Children: yes no If yes, please list ages and sex of the child:
_____

Extended Healthcare Insurance Company (if applicable):
_____

In case of emergency contact: _____
Relationship to patient: _____ Tel. No. _____

How did you find out about the naturopathic services at this clinic? _____

Last physician or health care practitioner seen, when and for what health concern?
_____
_____

When was your last blood test and what was it for? _____
_____ Blood type: _____

Health Concerns:
What are your chief health concerns? (in order of importance to you)
_____
_____
_____

_____
_____
_____

General state of health: □ poor □ fair □ good □ very good □ excellent
Comments:
_____
_____
_____
_____
_____
_____

Indicate which of the following you have or may have had:

□ abscess	□ frequent colds	□ low/high blood pressure	□ pleurisy	□ tonsillitis
□ abortion	□ gallstones	□ malaria	□ pneumonia	□ tuberculosis
□ alcoholism	□ genital herpes	□ measles	□ PMS	□ warts
□ anemia	□ genital warts	□ menstrual cramps	□ prostatitis	□ whooping cough
□ arthritis	□ gonorrhea	□ miscarriage	□ psoriasis	□ worms
□ asthma	□ gout	□ mono	□ rheumatic fever	
□ cancer	□ hay fever	□ multiple sclerosis	□ rubella	
□ chicken pox	□ headaches	□ mumps	□ scarlet fever	
□ cold sores	□ heart disease	□ parasites	□ skin diseases	
□ depression	□ HIV	□ peritonitis	□ sinusitis	
□ diabetes	□ influenza	□ pelvic inflammatory disease	□ stroke	
□ eczema	□ kidney disease		□ strep throat	
□ emphysema	□ leukemia		□ substance abuse	
□ epilepsy			□ syphilis	
□ fibrocystic breast disease				

Others: _____
_____
_____

List any accidents, injuries, surgeries and hospitalizations, (including type and year of occurrence):
_____
_____
_____
_____

List any known allergies (including food, drugs, herbs, environmental, etc.):
_____
_____
_____
_____

Typical diet (usual daily intake):
Breakfast: _____
Lunch: _____
Dinner: _____
Snacks:_____
Water: _____
Dietary restrictions/Food avoidances (provide reason):
_____

List daily intake of supplements (vitamins, minerals, herbs, etc.). Please indicate if self-prescribed or prescribed by a health care and duration of use:
_____
_____
_____
_____

Are you currently working with a medical doctor (MD)? □ Yes □ No
State diagnosis given by MD (if applicable): _____
_____

List any medical treatments you are undergoing and/or medications you are currently taking (if applicable), including dosage and duration of use:
_____
_____
_____
_____

Please indicate if you have worked or are currently working with other practitioners (e.g. chiropractor, physiotherapist, professional counsellor, psychologist, social worker, etc.). If in the past, please state when, reason for treatment and duration of treatment:
_____
_____
_____

Screening tests (include year of test and results):
_____
_____
_____
_____

Immunizations (include date and if you experienced any adverse effects from them):
_____
_____
_____
_____

Digestion:
Do you experience any gas or bloating? YES/NO
Which foods aggravate the condition? _____

Do you experience heartburn? YES/NO
Which foods aggravate the condition? _____
How many bowel movements per day? _____
Do you strain? YES/NO
Is there an urgency? YES/NO
The consistency of your bowels? Loose Diarrhea. Hard. Pellet Pencil-like
Other? _____
Undigested food in your stool? YES/NO

Sleep patterns:
Usual sleep and wake times: _____
Difficulty falling asleep? YES/NO _____
Difficulty staying asleep? YES/NO_____
Daytime naps? YES/NO. _____
Are your refreshed in the morning? YES/NO _____

Female Only Section:
Age of onset of Menses: _____
Regular Cycle: _____. Days in the Cycle: _____
Bleeding Days: _____. Heavy Light Normal
Pain? If yes, please describe pain and intensity? _____
Clots in flow? YES/NO Size of clots(quarter, nickel, dime)_____
PMS? If yes, please describe? _____

Moods: (Anxiety, depression, panic attacks, excessive worrying)
_____

What do you feel is your weakest organ system and why? _____
_____
_____

Do you exercise? □ Yes □ No
If yes, include type, frequency and duration:
_____
_____
_____
_____

What is your: height: _____ weight now? _____ max. weight? _____ min. weight? _____

Have you lost any weight lately? □ Yes □ No If so, how many pounds? _____

Indicate whether you have been or are exposed/use the following (and if so, how much):
□ tobacco smoke _____
□ coffee _____

□ tea _____
□ pop _____
□ alcohol _____
□ recreational drugs
_____
□ excess stress _____
□ chemicals _____

Indicate below any health conditions that have afflicted members of your family:

Relative	**Age if alive**	**Age at death**	**Health condition(s)**
Mother			
Father			
Brothers			
Sisters			
Children			
Maternal Grandmother			
Maternal Grandfather			
Paternal Grandmother			
Paternal Grandfather			

Describe you family/work relationships:

_____
_____
_____
_____

List important events/experiences in your life:

_____
_____
_____
_____

Private Policy: Personal health information is collected and managed by Dr. Zarlashta Popal in accordance with the Personal Health Information Protection Act (PHIPA). For more information please ask your health care provider, or go to www.ipc.on.ca

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