Simmonds McMurrer Naturopathic Clinic

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NEW PATIENT INTAKE FORM - ADULT

Name: _____ Date of Birth:_____ Today's Date: _____

PEI Health Card #_____ Insurance Provider:_____ Naturopathic Coverage:_____/yr

Age:_____ Gender: _____ Wt:_____ Ht:_____ Marital Status: _____ # of Children & ages: _____

Address: _____City:_____ Postal Code: _____

Phone Home: _____ Work:_____ Cell: _____ Email: _____

Occupation: _____ Employer: _____

Emergency contact: Name: _____ Relationship:_____ Phone: _____

Have you had naturopathic services? Yes/No: _____ If so when? _____

Date of last medical visit: _____ Reason for visit: _____

Family Physician: _____ Specialists:_____

Other Health Care Providers: _____

How did you hear about the clinic? _____

Past injuries: _____ Date(s): _____

Surgeries 1. _____ Date: _____ 2. _____ Date: _____

3. _____ Date: _____ 4. _____ Date: _____

Currently used medications (over the counter/prescribed) and Supplements (vitamins, herbs, protein)

Name (include brand for supplements)	Dosage and Frequency	Reason

Past prescription medications:_____

Number of antibiotic prescriptions in the past 5 years:_____ For what type of infections:_____

Reason for seeking naturopathic services: _____

_____

_____

Allergies (food, drug, environmental): _____

Dietary Restrictions (religious/vegetarian/vegan)_____

How often do you exercise? Type and duration? _____

Do you use any of the following?

Cigarettes: Yes ____ If yes, # times/day? ____ No ____ Vaping: Yes ____ If yes, # times/day? ____ No ____

Alcohol: Yes ____ If yes, # times/day? ____ No ____ Cannabis: Yes ____ If yes, # times/day? ____ No ____

Other drugs: Yes ____ If yes, # times/day? ____ type of drug (s)? No ____

Have you ever been exposed to toxins or hazards at home, work, or through hobbies? _____

_____

Family Health History: Indicate below if a close relative has had any of the following:

- ☐ **Alcoholism**
- ☐ **Allergies**
- ☐ **Alzheimer's**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Cancer**
- ☐ **Celiac**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Digestive Disorders**
- ☐ **Epilepsy**
- ☐ **Eczema**
- ☐ **Eye Disease**
- ☐ **Heart Disease**
- ☐ **Hypercholesterolemia**
- ☐ **Hypertension**
- ☐ **Kidney Disease**
- ☐ **Skin Disease**

Other Medical conditions_____

Indicate if any, of the following conditions you have had:

- ☐ **Abscesses**
- ☐ **ADD/ADHD**
- ☐ **Alcoholism**
- ☐ **Allergies**
- ☐ **Anemia**
- ☐ **Anxiety**
- ☐ **Arthritis**
- ☐ **Asthma**
- ☐ **Cankers**
- ☐ **Cancer**
- ☐ **Chicken Pox**
- ☐ **Chlamydia**
- ☐ **Cold Sores**
- ☐ **Crohn's/Colitis**
- ☐ **Depression**
- ☐ **Diabetes**
- ☐ **Emphysema**
- ☐ **Endometriosis**
- ☐ **Epilepsy**
- ☐ **Fibrocystic breasts**
- ☐ **Frequent Colds**
- ☐ **Fungal Infections**
- ☐ **Gallstones**
- ☐ **Gonorrhea**
- ☐ **Gout**
- ☐ **Hay Fever**
- ☐ **Headaches**
- ☐ **Heart Disease**
- ☐ **Hepatitis**
- ☐ **HIV**
- ☐ **HPV**
- ☐ **Herpes**
- ☐ **Infertility**
- ☐ **IBS**
- ☐ **Kidney Disease**
- ☐ **Leukemia**
- ☐ **Low/High Blood Pressure**
- ☐ **Lyme Disease**
- ☐ **Malaria**
- ☐ **Measles**
- ☐ **Migraines**
- ☐ **Miscarriage**
- ☐ **Mononucleosis**
- ☐ **Multiple Sclerosis**
- ☐ **Mumps**
- ☐ **Parasites**
- ☐ **Pelvic Inflammatory Disease**
- ☐ **Pneumonia**
- ☐ **Premenstrual Syndrome**
- ☐ **Prostatis**
- ☐ **Rheumatic Fever**
- ☐ **Scarlet Fever**
- ☐ **Sinusitis**
- ☐ **Sexual Abuse**
- ☐ **Stroke**
- ☐ **Strep Throat**
- ☐ **Syphilis**
- ☐ **Thyroid Disease**
- ☐ **Tonsilitis**
- ☐ **Uterine Fibroids**
- ☐ **Warts**
- ☐ **Whooping Cough**
- ☐ **Worms**
- ☐ **Yeast infectio**

Are you sexually active? ____ (Y/N) Any discomfort with intercourse? ____ (Y/N) Are you currently pregnant? _____ (Y/N)

Do you get any of the following screening tests done by another doctor:

PAP test_____ stool test_____ colonoscopy____ mammogram _____

Past vaccinations **Adverse Reactions?**

_____ _____
_____ _____
_____ _____

Any other conditions not mentioned or which you have not fully recovered:

_____
_____
_____

What is the emotional climate of your home? _____

Is your work stressful or other parts of your life? How do you manage stress? _____

_____

Please list the 5 most significant, stressful events in your life. Are they continuing to impact your life?

1. _____
2. _____
3. _____
4. _____
5. _____

NATUROPATHIC DECLARATION AND CONSENT TO TREATMENT

This is to acknowledge that I have been informed and understand:

1. Any treatment or advice provided to me as a patient of the clinic is not mutually exclusive from any treatment or advice that I may now be receiving or may receive in the future from another licensed health care provider.
2. I understand that Naturopathic Medicine is a comprehensive approach to health and illness and focuses on prevention and the use of natural, non-invasive methods of treatment and assessment.
3. I understand that any recommended treatments will be explained to me by the naturopathic doctor and that I will give consent to treatment based on informed consent.
4. I am at liberty to seek and/or continue medical care from a medical doctor or other qualified health care provider.
5. I am aware that no part of my treatment or testing is covered by Health PEI and that I am solely responsible for payment.
6. Payment is to be made in full at the time of my treatment. We will provide you with a receipt for submission to your insurance company when services are rendered.
7. Cancellation Policy: If you cannot make a scheduled appointment, please **call 24 hours in advance to reschedule**. Patients will be charged the full fee for a missed appointment.

I _____have read, understood, and agree to the above statements.

Patient's Full Name (please print)

Signature: _____Date of Consent: _____

Patient or legal guardian Day /Month/Year