Affinity Health Clinic
Naturopathic Intake Form

Patient Information **Date:**

Name: _____

Street Address: _____ APT# _____

City: _____ Prov. _____ Postal code _____

Home Phone: _____ Cell _____

Work Phone: _____ ext. _____ Email:_____

Birth Date (dd-mm-yy): _____

Height: _____ Weight: _____ Sex:_____

Occupation: _____ Employer: _____

Emergency Contact: _____Telephone: _____

Who recommended our services to you? _____

The best way to connect with you when we have clinic news: □ Facebook □ Email □ Other

Name of Family Doctor:_____ Phone # _____

Names of any illnesses and or conditions diagnosed by family doctor:

What are your goals/expectations in coming here?

How much are you willing to work to accomplish these goals? 0 1 2 3 4 5 6 7 8 9 10
(0= no work, 10 = I'll do anything)

Please list your chief health concerns in order of importance:

Complaint	Since	Possible causes

Affinity Health Clinic
3 Waterloo Street
New Hamburg, ON
N3A 1S3

www.affinityhealthclinic.ca
519-662-2123
wecare@affinityhealthclinic.ca

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Please list any allergies or sensitivities you have currently or have previously experienced:

Allergy/sensitivity	Since	Reaction	Possible causes

Please list all hospitalizations, surgeries and/or major injuries you have experienced:

Hospitalization/Injury	Year	Outcome/Complications

Please indicate which family relatives (mother, father, siblings, aunts, uncles or grandparents) have ever encountered the following health concerns:

Health Concern	Family Relative	Health Concern	Family Relative
Alcoholism		Hypertension	
Allergies		Infertility	
Alzheimer's disease		Intestinal disease	
Arthritis		Learning disability	
Asthma		Mental illness	
Cancer (indicate type)		Migraine headaches	
Diabetes		Neurological disorders	
Drug addiction		Obesity	
Eating disorder		Osteoporosis	
Genetic disorder		Stroke	
Glaucoma		Suicide	
Heart disease		Other	

# of siblings: _____ Your birth order: _____

Vaccinations: Please indicate which vaccinations you have received:

Vaccination	Y/N	Adverse effects?
Measles, Mumps, Rubella - MMR		
Diphtheria, Pertussis, Tetanus - DPT		
Haemophilus Influenza B - Hib		
Chicken Pox – Varicella Zoster		
Rabies		
Hepatitis A		
Hepatitis B		
Tetanus		
Polio		
Flu		
Other		

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Screening Tests and Health Exams: Please inform us of any screening tests or exams you have received

Test	Y/N	Results
CBC – Complete Blood Count		
Blood glucose		
Cholesterol		
PSA test (men)		
Digital rectal exam (men)		
Bone Mineral Density		
Mammogram		
Breast exam		
PAP test (women)		
Colonoscopy		
Spinal exam		
Hormone levels		
Vitamin D		
Physical exam		
Eye exam		
Dental check up		
Other		

Medications / Supplements
Please check any of the following medications that you are taking or have taken in the last 2 years:

□antacids	□chemotherapy	□radiation
□appetite suppressants	□diuretics	□recreational drugs
□aspirin/Tylenol	□laxatives	□sleeping pills
□birth control pills	□pain relievers	□tranquilizers

Any known drug allergies or drug sensitivities?_____

Number of times on antibiotics in the last 10years?_____

Number of times on corticosteroids in the last 10 years oral?_____Topical?_____

Drugs

Please list any pharmaceutical drugs you have taken within the last year

Name of Drug	Dosage / Amount	Reason for Taking	Duration of Use

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Vitamins, Supplements, Herbal or Homeopathic
Please list all natural supplements you have taken within the last year – please bring these with you to your appointment.

Name	Dosage / Amount	Reason for Taking	Duration of use

Review of Symptoms

Please circle if Y, P or N relate to you
Y = Yes, currently I am experience this
P = I have experienced this in the past
N = I have never experienced this

Skin, Hair and Nails

Rashes - specify	Y	P	N	
Skin conditions - specify	Y	P	N	
Dry skin	Y	P	N	
Itching	Y	P	N	
Changes in skin color	Y	P	N	
Sunburn (how often?)	Y	P	N	
Warts	Y	P	N	
Lumps or abscesses	Y	P	N	
Change in Mole	Y	P	N	
Skin cancer	Y	P	N	
Excessive perspiration	Y	P	N	
Night sweats	Y	P	N	
Strong body odour	Y	P	N	
Hair loss	Y	P	N	
Brittle nails	Y	P	N	

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Musculoskeletal

Joint pain/stiffness	Y	P	N	
Joint swelling	Y	P	N	
Arthritis	Y	P	N	
Muscle spasm/cramps	Y	P	N	
Muscle weakness	Y	P	N	
Bone fractures	Y	P	N	
Osteoporosis	Y	P	N	
Low back pain	Y	P	N	
Weak/sore knees	Y	P	N	

Head and Mouth and Throat

Headaches	Y	P	N	
Migraine headaches	Y	P	N	
Head injury	Y	P	N	
Dizziness	Y	P	N	
Jaw pain or clicking	Y	P	N	
Teeth grinding	Y	P	N	
Gum problems	Y	P	N	
Teeth problems	Y	P	N	
Bad breath	Y	P	N	
Dry mouth	Y	P	N	
Cold sores	Y	P	N	
Lumps	Y	P	N	
Post nasal drip	Y	P	N	
Poor sense of smell	Y	P	N	
Loss of smell	Y	P	N	
Runny nose	Y	P	N	
Nose bleeds	Y	P	N	

Ears

Impaired hearing	Y	P	N	
Ringing in ears	Y	P	N	
Earaches/infections	Y	P	N	
Itchy ear canal	Y	P	N	
Discharge from ear	Y	P	N	

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Eyes

Far sighted	Y	P	N	
Nearsighted	Y	P	N	
Color blindness	Y	P	N	
Poor night vision	Y	P	N	
Visual disturbances	Y	P	N	
Cataracts	Y	P	N	
Glaucoma	Y	P	N	
Blind spots/blindness	Y	P	N	
Double vision	Y	P	N	
Blurring	Y	P	N	
Sensitivity to sun	Y	P	N	
Itchy eyes	Y	P	N	
Dry eyes	Y	P	N	
Red eyes	Y	P	N	
Excessive tearing	Y	P	N	

Immune

Chronic infections	Y	P	N	
Cold sores	Y	P	N	
Frequent antibiotics	Y	P	N	
Frequent cold/flu	Y	P	N	
Frequent sore throat	Y	P	N	
Shingles	Y	P	N	
Slow wound healing	Y	P	N	
Swollen glands/lymph nodes	Y	P	N	

Respiratory System

Chronic cough	*Y*	*P*	*N*	
Chronic phlegm	Y	P	N	
Coughing up blood	Y	P	N	
Pain while breathing	Y	P	N	
Shortness of breath (when?)	Y	P	N	
Wheezing	Y	P	N	
Asthma	Y	P	N	
Chronic lung condition - specify	Y	P	N	

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Cardiovascular System

High blood pressure	Y	P	N	
High cholesterol	Y	P	N	
Angina	Y	P	N	
Chest pain	Y	P	N	
Heart murmurs	Y	P	N	
Heart palpitations	Y	P	N	
Heart attack	Y	P	N	
Anemia	Y	P	N	
Fainting	Y	P	N	
Dizziness upon standing	Y	P	N	
Easily bruised/bleed	Y	P	N	
Cold hands and/or feet	Y	P	N	
Numbness in hands/feet	Y	P	N	
Heaviness or pain in legs	Y	P	N	
Leg ulcers	Y	P	N	
Varicose veins	Y	P	N	
Your socks leave imprints on your ankles/leg swelling	Y	P	N	
Hemorrhoids	Y	P	N	

Gastrointestinal System

Change in thirst	Y	P	N	
Change in appetite	Y	P	N	
Trouble swallowing	Y	P	N	
Heartburn	Y	P	N	
Burping	Y	P	N	
Bloating	Y	P	N	
Gas	Y	P	N	
Nausea	Y	P	N	
Vomiting (vomiting blood)	Y	P	N	
Stomach cramps or pain	Y	P	N	
Ulcer	Y	P	N	
Constipation	Y	P	N	
Diarrhea or loose stool	Y	P	N	
Undigested food in stool	Y	P	N	
Mucous in stool	Y	P	N	
Black tarry stool	Y	P	N	
Blood in stool	Y	P	N	
Stool floats in toilet	Y	P	N	
Itching around anus	Y	P	N	

Liver disease	Y	P	N	
Gallbladder disease	Y	P	N	

How often do you have a bowel movement?_____
Have you ever travelled to another country? □ Y □N
Have you ever had parasites that you are aware of? □ Y □N
Any food sensitivities, intolerances, or allergies? _____
_____

Urinary System

Pain on urination	Y	P	N	
Blood in urine	Y	P	N	
Increased urinary frequency	Y	P	N	
Frequent bladder infections	Y	P	N	
Kidney infections	Y	P	N	
Kidney stones	Y	P	N	
Change in urine color/odor	Y	P	N	
Must strain to urinate	Y	P	N	
Inability to hold urine	Y	P	N	
Wake at night to urinate	Y	P	N	

Men's Health

Hernia	Y	P	N	
Testicular mass	Y	P	N	
Testicular pain	Y	P	N	
Prostate condition	Y	P	N	
Discharge or sores	Y	P	N	
Low sex drive	Y	P	N	
Sexual difficulties	Y	P	N	
Impotence	Y	P	N	
Sexually active? Sexual preference?	Y	P	N	
Venereal disease	Y	P	N	
Fertility issues	Y	P	N	

Women's Health

Vaginal discharge	Y	P	N	
Vaginal itching	Y	P	N	
Vaginal odor	Y	P	N	
Sores, growths or lumps	Y	P	N	
Abdominal pain mid cycle	Y	P	N	
Abnormal pap tests	Y	P	N	
Menopausal symptoms	Y	P	N	

Low sex drive	Y	P	N	
Sexual difficulties	Y	P	N	
Pain during intercourse	Y	P	N	
Vaginal dryness	Y	P	N	
Venereal disease	Y	P	N	

Breast Health

Fibrocystic breasts	Y	P	N	
Puckering of the skin	Y	P	N	
Nipple discharge	Y	P	N	
Tenderness	Y	P	N	
Flaky dry skin on nipple	Y	P	N	
Breast lump	Y	P	N	
Monthly self-breast exam	Y	P	N	
Last breast exam	Y	P	N	
Regular mammograms	Y	P	N	

Female Menstruation/Reproductive

Pain or cramping	Y	P	N	
Clotting	Y	P	N	
Diarrhea	Y	P	N	
Water retention	Y	P	N	
Bloating	Y	P	N	
Breast tenderness	Y	P	N	
Cravings	Y	P	N	
Mood swings	Y	P	N	
Headache	Y	P	N	
Light flow	Y	P	N	
Heavy flow	Y	P	N	
Bleeding between periods	Y	P	N	
Irregular cycles	Y	P	N	
Difficulty conceiving	Y	P	N	
Fertility treatments	Y	P	N	

Age of first menses:_____
Age of last menses (if applicable):_____
Average length of cycle (in days):_____
How many days is your menses?_____
Are you sexually active? □ Y □N Sexual preference?_____
What birth control do you use? (if any):_____
Number of pregnancies:_____

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Number of miscarriages:_____
Are you currently pregnant? □N □ Y how many weeks?_____

Endocrine

Diabetes	Y	P	N	
Excessive hunger	Y	P	N	
Excessive sweating	Y	P	N	
Excessive thirst	Y	P	N	
Excessive urination	Y	P	N	
Generally feeling cold	Y	P	N	
Generally feeling hot	Y	P	N	
Hormone therapy	Y	P	N	
Low blood sugar	Y	P	N	
Mental dullness	Y	P	N	
Poor concentration	Y	P	N	
Sluggish after coffee	Y	P	N	
Sluggish after eating	Y	P	N	
Thyroid trouble	Y	P	N	

Rate your energy level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10
At what time of day is your energy….best_____ worst_____
Rate your stress level (1=low, 10=high) 1 2 3 4 5 6 7 8 9 10
Have you recently lost weight? □ Y □N How much?_____

Sleep

Fall asleep easily	Y	P	N	
Wake up during the night (specific time?)	Y	P	N	
Difficulty falling asleep	Y	P	N	
Do not sleep/Insomnia	Y	P	N	
Night shift	Y	P	N	
Disturbing dreams	Y	P	N	
Eat before I sleep	Y	P	N	
Sleep 7-8 hours	Y	P	N	
Sleep with electronic device by my head	Y	P	N	
Have a good mattress?				

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Mental/Emotional

Abuse	Y	P	N	
Alcohol/drug abuse	Y	P	N	
Anxiety/nervousness	Y	P	N	
Depression	Y	P	N	
Easily angered	Y	P	N	
Indecision	Y	P	N	
Irritability	Y	P	N	
Memory problems	Y	P	N	
Mental illness	Y	P	N	
Mood swings	Y	P	N	
Panic attacks	Y	P	N	
Phobias	Y	P	N	
Prolonged grief/sadness				

What are the three major contributors to stress in your life:
1._____ 2._____ 3._____

Has there been an illness or event in your life that you feel you have never fully recovered from? Please specify if yes.

Lifestyle

Please indicate Y=Yes N=No and explain further where applicable

Have you ever been a smoker?	Y	N	
Are you exposed to second hand smoke?	Y	N	
Do you drink alcohol?	Y	N	
Do you use recreational drugs?	Y	N	
Do you spend time in nature? How much?	Y	N	
Do you exercise? How often and kind? (cardio, walking, weight bearing)	Y	N	
Do you drink water? How much?	Y	N	
Do you have dietary restrictions? (Religious, vegetarian..)	Y	N	
Do you drink pop? How much?	Y	N	

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Toxic Exposure

Please indicate Y=Yes N=No and explain further where applicable

Have you been exposed to mold, solvents, fumes, heavy metals, lead paint?	Y	N	
Are you sensitive to perfume, gasoline or other vapors?	Y	N	
Do you have mercury dental fillings?	Y	N	
Have you had root canal procedures?	Y	N	
Do you have any surgical implants?	Y	N	
Do you live near power lines?	Y	N	
Do you dye your hair?	Y	N	
Have you experienced health problems putting down new carpet, painting your home, using pesticides?	Y	N	