Action Health

7722 Elbow Drive SW, Calgary, AB, T2V 1K2 | Phone: 403.243.8114 | Fax: 403.212.0880

Natropathic Intake Form

Full Name: _____

Preferred Name: _____

Date of Birth (MM/DD/YYYY): _____ Sex: □ MALE □ FEMALE

Gender: □ MALE □ FEMALE □ Other: _____

Address: _____

_____

City: _____ Province: _____ Postal Code: _____

Home Phone: _____ Cell Phone: _____

Email Address: (for appointment reminders and monthly newsletters)

_____

Alberta Health Care: _____

Do you have group benefits? □ YES □ NO Through whom? _____

Emergency Contact Name and Phone Number: _____

How did you hear about our office? _____

Occupation: _____

Employer's Address (if known): _____

Is this injury the result of a work-related accident or a motor vehicle accident?

□ YES □ NO

If yes, please give the date of the accident: _____

Family Doctor's Name: _____ Phone Number: _____

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Previous Naturopathic Care Experience? If yes, when, where, and how successful was it?

1. _____
2. _____

Primary Health Concerns. Please list in order of importance and list the onset, frequency, and severity.

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

What are your goals for pursuing treatment?

1. _____
2. _____

List of current medications. Please list dose if known.

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

List of current supplements. Please list dose is known.

1. _____
2. _____
3. _____

4. _____

Allergies and Reactions:

1. Food Allergy:_____
2. Food Sensitivity:_____
3. Drug Allergy:_____
4. Drug Sensitivity:_____
5. Environmental:_____
6. Pet Allergy:_____

Past Medical History. Please explain fully and provide dates.

1. Chronic Conditions:_____
2. Surgeries:_____
3. Physical Trauma:_____
4. Mental/Emotional Health:_____
5. History of Recurrent Infections: _____
6. Other:_____

Family Medical History

1. Mother:_____
2. Father:_____
3. G. Mother:_____
4. G. Father:_____
5. Brother:_____
6. Sister:_____

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7. Children:_____

Childhood Health

1. Mom's health during pregnancy: _____
2. Antibiotics during pregnancy: _____
3. Breast fed: _____
4. Recurrent illness: _____
5. Frequent antibiotics: _____
6. Abuse or Trauma: _____
7. Vaccination history/reactions: _____
8. Other: _____