Dr. Linda Brown, B.A., N.D.
Naturopathic Doctor
www.WoodbridgeNaturopath.com
PATIENT INTAKE FORM

Name:_____ **Date:**_____

Address:_____ **Apt.#**_____
Number Street

_____
City Province Postal Code

Home#_____ **Bus.#**_____

Cell#_____ **E-Mail Address:**_____

Would you like to Join my Email List for Health Tips and Information? Yes _____ No _____

Date of Birth: _____/_____/_____ Age:_____ Height_____ Weight:_____

Physician:_____ **Referred by:** _____
Name please

How much are you willing to change in pursuit of good health?

_____

Main problem(s) you would like me to help you with?

_____

_____

To what extent does this problem affect your daily activities (work, sleep, eating, etc.)?

_____

How long has it been since you first noticed your symptoms?

_____

Have you been given a diagnosis for the problem? If so, what and by whom?

_____

What kinds of treatment have you tried?

_____

What other therapies are you receiving at this time?

_____

Medicines taken within the last two months (include vitamins, over-the-counter drugs, herbs, etc.):_____

Allergies (drugs, foods, hay fever, etc):_____

PAST MEDICAL HISTORY:

Significant Illnesses **(Circle): Cancer, Diabetes, High Blood Pressure, Heart disease, Hepatitis, Rheumatic fever, Thyroid Disease, Seizures, Other_____**

Surgeries:_____

Significant Trauma (auto accidents, falls, etc.):

_____

Occupation: _____ Since when? _____

Is it Stressful? _____ Do you enjoy your work? _____

Occupational Stresses (Chemical, Physical, Psychological, etc.):

_____

Exercise (Type and Frequency):

_____

AVERAGE DAILY DIET:

Morning:_____

Afternoon:_____

Evening:_____

Snacks:_____

HABITS (Circle all that apply):
Cigarettes, Coffee, Soft Drinks, Alcohol, Drugs, Sugar, Artificial Sweeteners, Salt, Other
_____

FAMILY MEDICAL HISTORY (Circle):
Diabetes, Cancer, High blood pressure, Heart disease, Stroke, Seizures, Asthma, Allergies, Alcoholism Other:_____

NEUROPSYCHOLOGICAL (Circle):

Seizures	**Areas of numbness**	**Poor memory**	**Concussion**
Depression	**Anxiety**	**Bad temper**	**Easily stressed**
Treated for emotional problems		**Considered/attempted suicide**	

Other neurological or psychological problems:_____

GASTROINTESTINAL:
Bowel movements: Frequency _____ Colour _____ Odour _____

Mucus/Blood? _____ Texture/Form _____ Pain or cramps? _____

Laxative use: _____ per week?

Bad Breath? _____ Appetite _____ Thirst _____

How much *plain* water do you drink per day?
_____

PREGNANCY and GYNECOLOGY:
Number of pregnancies _____ Number of births _____ Premature births _____ Miscarriages ____

Are you having fertility issues? _____

Age of first menses ____ Length of Flow _____(days) Irregular Periods? _____ Colour of Blood _____

Flow (heavy/light?) _____Last PAP _____Last Menses _____

Clots _____ Vaginal discharge _____ Vaginal sores _____Birth control type: _____

PMS symptoms prior to/during menses: _____

Menopause _____ (age) Menopausal Symptoms _____

Rate your energy level from 0 – 10 (with 10 as the highest) _____ Sudden energy drop _____ (time)

Do you normally feel Hot, Cold or Average? _____

Do you get regular physical exams? _____ Any abnormalities? _____

Do you have weight issues? _____ Thyroid issues? _____

****What are your goals for treatment?****

_____

It is my pleasure to help you on your journey to Good Health!

Dr. Linda L. Brown, B.A., ND
Naturopathic Medicine
www.WoodbridgeNaturopath.com
The Cove Healing Centre
180 Trowers Rd #28
Woodbridge, ON
L4L 8A6

For Appointments
Email: reception@TheCoveHealingCentre.com
Phone: (416) 873-5831