MISSION NATUROPATHIC CLINIC
202 – 2900 PANDOSY ST., KELOWNA, BC V1Y 1V9 (250) 862-8791

Welcome to the office of Mission Naturopathic Clinic! We are honoured that you have chosen us in your search for optimal health. Please fill out and sign the attached forms to the best of your ability, and bring them to the initial appointment. It will aid in your assessment of your present health, and facilitate in your process of healing.

If you wish to cancel or reschedule you appointment; please do so **48 hours** or more before your appointment. We do reserve the right to **charge full cost** of the visit for missed appointments, or if insufficient time is given for cancellations. We will confirm your appointment 2 days prior to your visit by phone or leave a voice mail when necessary. If you are undergoing any treatments, please do not come on an empty stomach, as this may raise some of the risks associated with therapies. If you have any questions, please call our office at (250) 862-8791 or speak to the reception staff. We look forward to growing with you!

Note: many of our patient are sensitive to environmental substances; therefore, we ask that all patients refrain from wearing scented hairsprays, colognes, perfumes aftershaves, etc., on the day of your appointment.

Payment Requirements: Appointments must be paid for at the time of service. We accept VISA, MC, Debit, and cash.

Records: We keep a record of your health care services. We will not disclose your records to others unless you direct us to do so, or unless the law authorizes us to. You can obtain copies of the files for a small fee upon signing an authorization form. Please allow up to 10 working days to process the request.

Insurance: Mission Naturopathic Clinic does not directly bill insurance companies. You may submit your paid invoice to your insurance company for reimbursement. We are also not a Government Funded healthcare provider, and no reimbursement will by honoured by this organization.

I understand that I will have asked a Dr. Berg, Dr. Chambers, and/or Dr. Wolter of Mission Naturopathic Clinic for help and that she will help to the best of her ability.

I have read and understand the above statements.

______________________	______________________	__________
Print Name	Signature (signed by guardian if under-age)	Date

Mission Naturopathic Clinic

Adult Intake Form

Date:________________________ How did you hear about us?____________________

Name:____ Birth date:(M)___/(D)___/(Y)____
Last First Middle Initial

Personal Health Care Number: ______________________

Address:____

City:_______________________ Province:________________ Postal Code:_________________

Phone: Work:_________________ Home:_________________ Email:______________________

Relationship Status: _______________________ Occupation:______________________________

Children: Y N Ages and Sex:____

Emergency Contact: ______________________________ Number:____________________________

Height: ___________________________ Weight:_____________________

Max weight:_______________________ When: ______________________

Please list any Practitioners that you are currently seeing (conventional and/or alternative)

Name:	Number:	How long:

Please list your chief concerns in order of importance:	**Onset:**	**Frequency:**	**Severity:**
Example: Headaches	*June '91*	*3 X week*	*Mild/mod/severe*
1.			
2.			
3.			
4.			
5.			

What are your goals for this visit? ____
____
____

Have you been given a diagnosis from other practitioners for any of these problems – if so what?
____
____

Please fill in this form with any prescription medication, vitamin, mineral, amino acid, or other supplements that you may be taking:

MEDICATION/ SUPPLEMENTATION	BRAND	FORM	DOSAGE	FREQUENCY
Example: Beta Blocker	*Metoprolol*	*Pill*	*200mg*	*1x day*

Comments: ____

Please fill in this form with any non-prescription medication that you may be taking:

MEDICATION/ SUPPLEMENTATION	BRAND	FORM	DOSAGE	FREQUENCY
Example: Vitamin C	*Natural Factors*	*Tablet*	*500mg*	*3 X day*

Comments: ____

PAST MEDICAL HISTORY:

Hospitalizations: ____
____
Surgeries (year and type): ____
____
Serious Illnesses/ Accidents/ Injuries (year, cause, and injury): ____________________
____

Have you ever used general anaesthetic? Y N When? ____________________

Antibiotic use? Y N When? ____________________________________

Allergies (type and onset)? ____
____
Pets (what kind and how many)? ____
____

Women:

Last Pap: ______________ First day of last menstrual period: ____________________
Days to cycle *(start to start):* _____ Days of Bleeding: _____ Age of first menses: ______
Menstrual difficulties: Cramping Heaviness Spotting Irregularity No period
No. of pregnancies: _______ deliveries: _______ Complications: ____________________

Dental:
Please note to the best of your knowledge all dental work/treatments you have undergone including fillings (type), pulled teeth, root canals, dentures, braces, retainers, accidents, other.____
____

Childhood Illnesses:
Health as a child: (1) Poor to (10) Excellent___________ Explanation: ___________________

___ Rheumatic fever ___ German Measles ___ Polio
___Allergies ___ Chicken pox ___ Mumps
___ Asthma ___ Ear infections ___ Skin conditions

Vaccinations: (please check all that apply)
( ) DPT (Diphtheria, Pertussis, Tetanus)
( ) Booster (usually DT)
( ) Polio injection ( ) Polio oral
( ) MMR (Measles, Mumps, Rubella)
( ) HBV (Hepatitis B Vaccine)
( ) Other (flu shot, etc)

Family History:
Has anyone in your immediate family had any of the following:

___Cancer ___High blood pressure ___Diabetes
___Heart Disease ___Allergies ___Arthritis
___Epilepsy ___Glaucoma ___Mental Illness
___Alcoholism ___Stroke ___Obesity
Other ____

CURRENT HEALTH SYSTEMS (circle all that apply):

Sleep: Number of hours:_____ Trouble falling asleep: Y / N Trouble staying asleep: Y / N
Mind restlessness: Y / N Body Restlessness: Y / N Refreshed upon waking: Y / N

Energy: High Moderate Low Times that are worse than others: ______

Digestion: Problems with (circle all that apply): Indigestion Upset stomach Heartburn
Belching GERD Nausea Bloating Gas Cramping
Bowel movements: _____ x day color: _________________
(circle all that apply): Blood Mucus Undigested foods Pain
Anal itching Hemorrhoids Constipation Diarrhea

Genitourinary: History of: Bladder Infections Kidney stones Other Kidney disease
Sexually transmitted infection Vaginal/genital infections Pain

Lung: History of: Frequent Cough Shortness of breath Smoking
Frequent infections Asthma Allergies Other

Cardiovascular: History of: Heart attack Stroke Palpitations Murmur
High Blood Pressure Arrhythmias Varicose veins Poor circulation
Nervous System: Numbness Tingling Atrophy Pinched Nerves Pain

Musculoskeletal: Injury Joint Pain Muscle Pain Muscle Fatigue Spasms Muscle cramps Osteoporosis Arthritis Other

Ears: Pain Ringing Deafness Frequent infections Other

Nose: Allergies Sinus congestion Post Nasal Drip Surgery Other

Eyes: Blurred vision Visual impairment Injury Floaters Pain Other

Throat: Frequent infections Thyroid issues Loss of voice Pain Tonsillectomy

Skin/Hair: eczema acne psoriasis fungal hives hair loss dryness other

Toxin Exposures: (circle all)

1) Cigarette smoke: first hand second hand past present

2) Dental: silver fillings past present removed

3) Home: older than 1975 (present/past) old piping water damage/mold asbestos new carpets new cabinetry chemical cleaners use air fresheners pets attached garage natural gas appliances

3) Food: organic _______% of food tap water plastics used

4) Personal: wear perfumes petroleum products use dry-cleaning use antibacterial soap deodorants fluoride

5) Occupation: (past or present) painter work with plastics work with chemicals construction industry gasoline insulation cleaning dentistry farming hair stylist esthetician with automobiles driver landscaping/planting
other:____

6) Live near: golf course orchard/farm mine factory

7) Other: frequent flying golfing aspartame sprays with gardening

LIFESTYLE:

Please indicate your consumption level of the following?

	NONE	LIGHT	MODERATE	HEAVY
Salt	☐	☐	☐	☐
Sugar	☐	☐	☐	☐
Caffeine	☐	☐	☐	☐
Tobacco	☐	☐	☐	☐
Alcohol	☐	☐	☐	☐
Recreational Drugs	☐	☐	☐	☐
Exercise	☐	☐	☐	☐
Water	☐	☐	☐	☐

24 Hour Diet Recall:

Breakfast: ____________________

Lunch: ____________________

Dinner: ____________________

Snacks: ____________________ Beverages: ____________________

Daily Water intake: ____________________ Foods Avoided: ____________________

Food Cravings: ____________________ Food Allergies: ____________________

Level of Stress (circle one): High Moderate Low What are the major stressors in your life?

____

____

____

Do you have a good support network (family, friends, groups)? ____________________

What is your current living situation? ____________________

Do you currently follow a (religious/spiritual) belief system? ____________________

Do you: Meditate Pray Use visualizations Other relaxation techniques ____________________

Hobbies? ____________________

Any Further Comments or Concerns? ____________________

____