



New Patient Intake Form

Date_____

Name_____

Address_____ Phone #_____

City, Province_____ Postal Code_____

Date of Birth (M/D/Y)_____ Email Address _____

Sex: M or F Age: _____ Marital Status S M D W

Occupation_____

Address_____

City_____

Phone #_____

Provincial Health Card Number_____

Prior Naturopathic

Name_____ Phone#_____

Medical Doctor:

Name_____ Phone#_____

Address_____

How did you hear about our office:_____

Medications/ Supplements

Please list all current medications (prescription and over-the-counter), the daily dose and how long you have taken it.

Medications	Dosage	How long?	Medications	Dosage	How long?
1.			4.		
2.			5.		
3.			6.		

Please list all current vitamins/minerals, herbs, or homeopathies, the daily dose and how long you have taken it.

Supplements	Dosage	How long?	Supplements	Dosage	How long?
1.			5.		
2.			6.		
3.			7.		
4.			8.		

Allergies (Please list all known)

Allergies	Items	Reactions
Medications		
Foods		
Environment		
Animals		