With Love from Nature & Grace

Natural Care Clinic

CLIENT INTAKE – FORM 2:
HEALTH SURVEY

Today's Date		NCC- MRN #	

Full Name:			Middle Name:
Date of Birth:			Gender:
Address:			
City:	Province:	Postal Code:	Country:
Mobile No.:		Home Phone:	
Work Phone:		Occupation:	
Email:			

Medical Doctor:	Contact No.:
Other Health Care Provider:	Contact No.:

IN CASE OF EMERGENCY, NOTIFY:	
Relation:	Contact No.:

Allergies	**Medications**

Would you like to receive emails that include newsletters, health tips, and upcoming events?	Y	N
How Did You Hear About Us?		

How would you like to receive reminders for your upcoming appointments? **(select one)** WhatsApp (Text)
☐ Email:
☐ Text:

Office Policy
Your appointment time will be reserved for you. If you are unable to keep the appointment, we will require 48-hours (2-business days) notice, otherwise it may be necessary to charge for the time lost.

What is your primary health concern	
What are your goals for your health at this time?	
When did this condition first begin?	
Is this a recurring problem? ☐ Yes ☐ No	Is this getting better or worse? ☐ Better ☐ Worse
What do you feel is the cause of the problem?	
What does it feel like?	
What aggravates your symptoms?	
What alleviates your symptoms?	
Are there any other related symptoms?	
Are you receiving treatment for this? ☐ Yes ☐ No If YES – what kind?	
Have you ever received any of the following? **(select ALL that applies)** ☐ Naturopathic Treatment ☐ Chiropractic Treatment ☐ Acupuncture Treatment	
Have you had a personal injury or accident this past year? ☐ Yes ☐ No	
Please describe:	
Other health concerns? **(please list)**	
Have you ever been treated for a serious or infections disease? (pneumonia, tuberculosis, Lyme, etc.)	
☐ Yes ☐ No If YES – what kind?	

List any prescribed medication, over-the-counter drugs, vitamins and nutritional supplements				
Medication	Age Started	Length of Use	Dose	Side Effects
List any birth control use or hormone replacement therapy (oral, injection, IUD):				
Medication	Age Started	Length of Use	Dose	Side Effects

Family Health History	Describe	Family Member
Allergies/Asthma		
Alzheimer's/Parkinson's		
Anxiety/Depression		
Autoimmune Disease		
Cancer		
Diabetes		
Gastrointestinal Disease		
Heart Attack/Disease		
Liver Disease		
Lung Disease		
Overweight/Obese		
Prostate Disease		
Stroke		
Thyroid Disease		
Other:		
More info:		

Lifestyle & Health Habits				
Exercise	☐ No exercise			
	☐ Mild exercise *(ie. Climb stairs, walk 3 blocks, golf)*			
	☐ Occasional, vigorous exercise *(ie. Workout/recreational, less than 4 times per week for less than 30 minutes, yoga/pilates)*			
	☐ Regular, vigorous exercise *(4 or more times per week for 30 minutes)*			
	☐ Other(please describe):			
Diet	Are you dieting?	☐ Yes/How:		☐ No
	Avoiding anything?		# of meals in a day?	
	Indicate below your intake of meals per day			
	High sugar intake	☐ Most meals	☐ About ½	☐ Few meals
	High salt intake	☐ Most meals	☐ About ½	☐ Few meals
	High fat intake	☐ Most meals	☐ About ½	☐ Few meals
Caffeine	Number of cups/can per day/per week:			
	☐ Pop/Soda	☐ Coffee	☐ Tea	☐ None
Alcohol	Do you drink alcohol? ☐ Yes ☐ No			
	If yes, what kind?			
	How many drinks per week?		How many drinks per month?	
Tobacco	Do you use tobacco? ☐ Yes ☐ No			
	If yes, in what form (cigarettes, chew, pipe, vape etc.)?			
	Frequency of use per day:			
	Age started:	How many years?	Year you quit:	
Substance Use	Do you use any recreational drugs? ☐ Yes ☐ No			
	If yes, please describe:			
	Do you use any other drugs or substances no listed already? ☐ Yes ☐ No			
	If yes, please describe:			
Sexual Health	Are you currently, sexually active? ☐ Yes ☐ No			
Environmental Exposure	Do you have mercury or silver amalgam fillings? ☐ Yes ☐ No			
	Have you had any root canals? ☐ Yes ☐ No			
	Do you use hair dyes?		Frequency:	
	Do you use pesticides or herbicides?		Frequency:	
	Are you frequently exposed to any chemicals? (paints, solvents, cleaning solutions, plastics, etc.)			
	Other toxins (mold, asbestos, radiation, etc.):			

Check and briefly explain if you have, or in the past have had, any symptoms in the following areas:	
☐ Skin (ie. Eczema, rashes, hives)	☐ Heartburn/Indigestion/Acid Reflux
☐ Hair loss/growth	☐ Gas/bloating
☐ Head/Neck	☐ Bowels (constipation, loose stools)
☐ Ears, Nose/Sinuses	☐ Bladder/Urination
☐ Throat	☐ Back/Spine
☐ Lungs/Asthma	☐ Reproductive/Libido
☐ Chest/Heart	☐ Gynecological/Periods
☐ Immune System (Ie. Colds/infections)	☐ Hormones
☐ Circulation	☐ Emotional
Any recent changes with the following? Please describe.	
☐ Appetite/Thirst	☐ Weight
☐ Focus/Concentration	☐ Energy Level
☐ Memory	☐ Ability to sleep (ie. Falling/staying asleep)
☐ Mood (ie. Anxiety, low mood)	☐ Temperature
Other pain/discomfort:	

Are there any significant life events or stressors that contribute to your over health? Is there anything else that you feel is important about your health or lifestyle? Please describe.

Please complete the following in chronological order, from birth to present, using the approximate age of occurrence		
Surgery		**Age**
Serious Infections/Diseases *(pneumonia, mono, TB, cancer, heart attack, chronic bronchitis, colitis, etc.)*		**Age**
Dental Intervention *(Root canals/extractions, 1st silver amalgam filling, braces, retainer, etc.)*		**Age**
Injuries/Accidents	**With Stitches?** *(Y/N)*	**Age**

Additional Information Please use this page to add more information about medications/supplements, family health history, lifestyle and health habits, diet, symptoms, and anything else about your health that you feel is important