Dr. Véronic Provencher MSc ND

CONFIDENTIAL INTAKE FORM

PATIENT INFORMATION

Date:____

First Name:__________________________________
Last Name:__________________________________
Middle Initial(s):____Preferred Name:_____________

Home Address:_______________________________
City:_______________________________________
Province:_______Postal Code:__________________
Phone:(home)________________________________
(cell)______________________________________
(work)_____________________________________
May we leave messages relating to your visits?
□ Yes □ No
Email:______________________________________

Date of birth: (D)____(M)____(Y)______Age:________
Gender: □ male □ female
Marital Status:□ single □ married □ divorced □ widowed
Number of kids and ages:______________________
Ethnicity:___________________________________
Occupation:_________________________________
Education: □ high school □ college diploma
□bachelor's degree □master's degree □doctoral degree
Alberta Health Care #:__________________________

Person to contact in case of emergency:
Name:______________________________________
Relationship:_________________________________
Phone: (home)________________________________
(cell)_______________________________________
(work)______________________________________

How did you hear about Dr. V:___________________
Have you ever been treated by a ND? □ Yes □ No
By whom:______________When:________________
Reason:_____________________________________

Names of other health care providers (include phone numbers if known):
Medical Doctor:_______________________________
Naturopathic Doctor:___________________________
Specialist:____________________________________
Other:_______________________________________

PATIENT HEALTH INFORMATION

Main health concerns in order of importance:
1.____
2.____
3.____
4.____
5.____

List any **diagnoses** received for any of your medical concerns (including who provided the diagnosis):
1.____
2.____
3.____

List all **medications and supplements** that you are taking (include dose and how often you take them):
1.____
2.____
3.____
4.____
5.____
6.____
7.____
8.____
9.____
10.____

Allergies (food, drugs, environmental) and reactions:
1.____
2.____
3.____
4.____

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Immunizations (including reactions if applicable):

____

____

____

____

Surgeries and hospitalizations (include year):

____

____

Check which of the following you **use** (include how often items are used and specify type if necessary):

	Daily	Weekly
□ Pain Killers	_____	_____
(type?)_____		
□ Antacids	_____	_____
□ Laxatives	_____	_____
□ Energy Boosters	_____	_____
□ Diet Pills	_____	_____
□ Sweeteners	_____	_____
(type?)_____		
□ Coffee	_____	_____
□ Recreational Drugs	_____	_____
(type?)_____		
□ Tobacco	_____	_____
□ Alcohol	_____	_____
□ Sweets	_____	_____
□ Fast Food	_____	_____
□ Exercise	_____	_____
(type?)_____		
□ Meditation	_____	_____

Foods or items that you currently **avoid** (and reason):

1.____________________

2.____________________

3.____________________

Favourite foods (or foods that you **eat most often**):

1.____________________

2.____________________

Family History (check all that apply and note which family member has the condition and type if known):

- □ Alcoholism ____________
- □ Allergies ____________
- □ Arthritis ____________
- □ Asthma ____________
- □ Autoimmune disease ____________
- □ Blood disorder ____________
- □ Cancer ____________
- □ Dementia ____________
- □ Depression ____________
- □ Diabetes ____________
- □ Epilepsy ____________
- □ Genetic disease ____________
- □ Hay fever ____________
- □ Heart disease ____________
- □ High blood pressure ____________
- □ Kidney disease ____________
- □ Mental Illness ____________
- □ Neurological disorder ____________
- □ Obesity ____________
- □ Respiratory disease ____________
- □ Stroke ____________
- □ Thyroid disease ____________
- □ Other ____________

Review of Symptoms

Blood Type: ____________________

Height:__________Weight:__________

Any major weight changes in the past year? □ Yes □ No

If yes, how much:____________________

Do you have any medical alerts?____________________

How many hours per night do you average of **sleep**?

____

Do you wake rested? □ Yes □ No

Do you wake at night? □ Yes □ No

If yes, why?____________________

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Check any condition that are **presently** causing problems. Type a **"P"** next to the conditions which were a problem for you in the **past**.

General

- ☐ __ Bleed/bruise easily
- ☐ __ Change in appetite
- ☐ __ Chills
- ☐ __ Cravings
- ☐ __ Fatigue
- ☐ __ Fevers
- ☐ __ Night sweats
- ☐ __ Peculiar tastes/smells
- ☐ __ Poor appetite
- ☐ __ Poor sleep
- ☐ __ Strong thirst
- ☐ __ Sudden energy drop
- ☐ __ Sweat easily
- ☐ __ Weight gain
- ☐ __ Weight loss

Skin and Hair

- ☐ __ Change in hair/skin
- ☐ __ Dandruff
- ☐ __ Eczema
- ☐ __ Hives
- ☐ __ Itching
- ☐ __ Loss of hair
- ☐ __ Pimples
- ☐ __ Rashes
- ☐ __ Recent moles
- ☐ __ Ulcerations
- ☐ __ Other:___________

Head, Eyes, Ears, Nose, and Throat

- ☐ __ Blurry vision
- ☐ __ Cataracts
- ☐ __ Colour blindness
- ☐ __ Dry mouth
- ☐ __ Earaches
- ☐ __ Eye pain/strain
- ☐ __ Facial pain
- ☐ __ Frequent colds
- ☐ __ Gum problems/sores
- ☐ __ Headaches
- ☐ __ Jaw clicks/pain
- ☐ __ Migraines
- ☐ __ Night blindness
- ☐ __ Nose bleeds
- ☐ __ Poor hearing
- ☐ __ Recurrent sore throats
- ☐ __ Ringing in ears
- ☐ __ Sinus problems
- ☐ __ Sores on lips/tongue
- ☐ __ Tooth pain
- ☐ __ Using glasses
- ☐ __ Other:______________

Cardiovascular and Circulatory Systems

- ☐ __ Angina
- ☐ __ Calf/leg pain
- ☐ __ Chest pain
- ☐ __ Cold hands/feet
- ☐ __ Fainting
- ☐ __ Heart attack
- ☐ __ High blood pressure
- ☐ __ Irregular heartbeat
- ☐ __ Low blood pressure
- ☐ __ Rapid heartbeat
- ☐ __ Stroke
- ☐ __ Swelling of feet
- ☐ __ Swelling of hands
- ☐ __ Varicose veins
- ☐ __ Other:___________

Respiratory System

- ☐ __ Asthma
- ☐ __ Bronchitis
- ☐ __ Chronic cough
- ☐ __ Coughing blood
- ☐ __ Difficulty breathing
- ☐ __ Pain with a deep breath
- ☐ __ Pneumonia
- ☐ __ Production of phlegm (colour:__________)
- ☐ __ Other:___________

Gastrointestinal System

- ☐ __ Abdominal pain
- ☐ __ Bad breath
- ☐ __ Belching
- ☐ __ Bloating
- ☐ __ Blood in stool
- ☐ __ Constipation
- ☐ __ Diarrhea
- ☐ __ Excessive hunger
- ☐ __ Gas
- ☐ __ Heart Burn
- ☐ __ Hemorrhoids
- ☐ __ Indigestion
- ☐ __ Nausea
- ☐ __ Poor appetite
- ☐ __ Rectal pain
- ☐ __ Vomiting blood
- ☐ __ Other:____________

Genito-Urinary System

- ☐ __ Blood in urine
- ☐ __ Decrease in flow
- ☐ __ Distinctive colour
- ☐ __ Wake to urinate
- ☐ __ Frequent urination
- ☐ __ Kidney stones
- ☐ __ Pain on urination
- ☐ __ Sores on genitals
- ☐ __ Unable to hold urine
- ☐ __ Urgency to urinate
- ☐ __ Urinary tract infections
- ☐ __ Other:____________

Muscles, Joints, and Bones

- ☐ __ Arthritis
- ☐ __ Back pain
- ☐ __ Foot/ankle pain
- ☐ __ Hand/wrist pain
- ☐ __ Hip pain
- ☐ __ Muscle weakness
- ☐ __ Neck pain
- ☐ __ Shoulder pain
- ☐ __ Swollen joints
- ☐ __ Other:______________

Neurological and Psychological Systems

□ __ Anxiety □ __ Concussion
□ __ Depression □ __ Dizziness
□ __ Emotional □ __ Lack of coordination
□ __ Loss of balance □ __ Numbness
□ __ Poor memory □ __ Quick temper
□ __ Seizures □ __ Stress
□ __ Suicidal tendency □ __ Tremors
□ __ Worry □ __ Others:____________

Men

□ __ Discharge or sores □ __ Hernias
□ __ Herpes □ __ Impotency
□ __ Premature ejaculation
□ __ Prostate disease □ __ Sexually transmitted infection (type?) __________________
□ __ Testicular masses □ __ Testicular pain
□ __ Other:_____________

Women

Age of first menses:________ Length of cycle:_________
Date of last menses:_______ Duration of menses:_____
pregnancies:____________ # miscarriages:_________
births:_________________ # abortions:____________
□ __ Abnormal menses □ __ Abnormal pap
□ __ Birth control (type?) ___________________________
□ __ Bleeding between periods
□ __ Breast lumps □ __ Clots (during menses)
□ __ Endometriosis □ __ Heavy menses
□ __ Hot flashes □ __ Mood swings
□ __ Nipple discharge □ __ Ovarian cysts
□ __ Pain on intercourse □ __ Painful discharge
□ __ Cramping □ __ Sexual difficulties
□ __ Sexually transmitted infection (type?)__________
□ __ Vaginal discharge □ __ Vaginal sores
□ __ Yeast infections □ __ Other:_______________

Environmental

□ __ Mercury fillings (how many?__________________)
□ __ Live or work in industrial area
□ __ Live or work near area where pesticides and herbicides are used (golf course, orchard, etc)
□ __ Live close to high voltage power lines
□ __ Became ill after moving to a different building or home
□ __ Exposed to chemicals (specify: ________________)
□ __ Exposed to mold or excessive moisture
□ __ Exposed to fluorescent lighting (how often?____)
□ __ Chemically sensitive (specify if compounds known:____)
□ __ Sleep on a water bed
□ __ Use electric blanket
□ __ Use a microwave to heat foods
□ __ Have pets (what kind?_______________________)

Other

Anything else that you feel is important that has not been covered?

____
____
____
____

Other Information

What is the most important concern that you have?

____

How will you assess that this concern has been appropriately addressed?

____

What are you expectations of Dr. V?

____

What modalities are you most drawn towards:

□ Herbs □ Vitamins/Minerals
□ Nutrition □ Homeopathy
□ Acupuncture □ IV therapy
□ Neural therapy □ Chelation

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