

**Banff Naturopathic Medical Clinic, Dr. Samantha Frey BSc, ND**

Suite 209, 215 Banff Avenue, Banff, AB, T1L 1E2  
T 762-4325 F 762-4326 [www.banffnaturopathic.com](http://www.banffnaturopathic.com)

**ADULT INTAKE FORM**

*This information is strictly confidential and is only used in accordance with our privacy policy.*

Patient Name: \_\_\_\_\_

Mailing Address: \_\_\_\_\_

E-mail Address: \_\_\_\_\_

Phone #s : \_\_\_\_\_

Occupation and hours per week: \_\_\_\_\_

Date of birth (M/D/Y): \_\_\_\_\_ Sex: \_\_\_\_ Age: \_\_\_\_

Live with: Spouse \_\_\_\_ Parents \_\_\_\_ Children \_\_\_\_ Friends \_\_\_\_ Alone \_\_\_\_

Emergency contact person and #:  
\_\_\_\_\_

Would you like to be contacted via e-mail for upcoming events, specials, or new services (your e-mail address remains confidential)? Y/N

Have you been to a Naturopathic Doctor before? Y/N

Name of Medical Doctor(s): \_\_\_\_\_

Do you have regular medical exams?: Y/N

Do you have regular dental exams?: Y/N

Please list any allergies (drugs, foods, environmental) and how they were diagnosed:  
\_\_\_\_\_  
\_\_\_\_\_

What is your current weight? \_\_\_\_\_ One year ago? \_\_\_\_\_ Ideal? \_\_\_\_\_

What health concern(s) have brought you to our office, in order of importance to you?

1. \_\_\_\_\_

2. \_\_\_\_\_

3. \_\_\_\_\_

4. \_\_\_\_\_

5. \_\_\_\_\_

How have you tried to treat the problem(s) and with what results?  
\_\_\_\_\_  
\_\_\_\_\_

What, if any, diagnosis have you been given?  
\_\_\_\_\_  
\_\_\_\_\_

What is your goal in coming to our office? \_\_\_\_\_  
\_\_\_\_\_

Are you willing to be an active participant in your health? Y/N

**YOUR MEDICAL HISTORY**

Please fill in the appropriate box: if “yes” indicate current with “C”, past with “P”

	Yes	No		Yes	No		Yes	No
Anemia			Diabetes			Kidney Disease		
Arthritis			Epilepsy			Liver Disease		
Asthma			Gallbladder Disorder			Multiple Sclerosis		
Cancer			Heart Disease			Rheumatic fever		
Crohn’s or Ulcerative colitis			Hepatitis			STD		
Depression			HIV/AIDS			Thyroid disorder		

Have you ever been hospitalized or had surgery? (Please list why and when)

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Please list past prescription medications:

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Do you take any of the following on a regular basis (please circle):

Laxatives, Tums or antacids, Pepto Bismol, cortisone, tranquilizers, pain relievers (Tylenol, Aspirin), appetite suppressants, thyroid medications, anti-inflammatories (ibuprophen).

Were you ever on antibiotics for any extended period of time? Y / N

**PLEASE LIST CURRENT MEDICATIONS**

Name	Dosage (mg or # pills)	Frequency	For how long?

**PLEASE LIST CURRENT SUPPLEMENTS** (vitamins, herbs)

Name and brand	Dose (mg or # pills)	Frequency	For how long?

**FAMILY MEDICAL HISTORY** – please circle those conditions that family members (blood relatives) have developed.

Asthma/allergies	Digestive disorders	High blood pressure	Thyroid disorder
Arthritis	Drug/alcohol abuse	High cholesterol	Visual problems
Cancer	Epilepsy	Kidney disease	Other:
Depression	Genetic diseases	Liver disease	
Diabetes	Heart disease	Mental illness	

I don't know my family history \_\_\_\_\_

**YOUR LIFESTYLE** Do you use, or are you exposed to any of the following (list approximate amount)

Alcohol	Y N	Caffeine	Y N
Marijuana	Y N	Occupational hazards	Y N
Cigarette smoke	Y N	Environmental toxins	Y N
Illicit drugs	Y N	Animals	Y N

Do you have any particular food restrictions (religious, ethical)

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**SKIN AND HAIR**

- |   |                                       |   |
|---|---------------------------------------|---|
| <input type="checkbox"/> Rashes                         | <input type="checkbox"/> Loss of hair | <input type="checkbox"/> Changing moles |
| <input type="checkbox"/> Ulcerations                    | <input type="checkbox"/> Pimples      | <input type="checkbox"/> Hives          |
| <input type="checkbox"/> Eczema                         | <input type="checkbox"/> Recent moles | <input type="checkbox"/> Dandruff       |
| <input type="checkbox"/> Change in hair or skin texture | <input type="checkbox"/> Itching      |   |

Any other hair or skin problems? \_\_\_\_\_

## **HEAD, EYES, EARS, NOSE AND THROAT**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> Dizziness       | <input type="checkbox"/> Color blindness        | <input type="checkbox"/> Nosebleeds              |
| <input type="checkbox"/> Concussions     | <input type="checkbox"/> Cataracts              | <input type="checkbox"/> Recurrent sore throats  |
| <input type="checkbox"/> Migraines       | <input type="checkbox"/> Blurry vision          | <input type="checkbox"/> Grinding teeth          |
| <input type="checkbox"/> Glasses/contact | <input type="checkbox"/> Earaches               | <input type="checkbox"/> Facial pain             |
| <input type="checkbox"/> Eye strain      | <input type="checkbox"/> Ringing in ears        | <input type="checkbox"/> Sores on lips or tongue |
| <input type="checkbox"/> Eye pain        | <input type="checkbox"/> Poor hearing           | <input type="checkbox"/> Teeth problems          |
| <input type="checkbox"/> Poor vision     | <input type="checkbox"/> Spots in front of eyes | <input type="checkbox"/> Jaw clicks              |
| <input type="checkbox"/> Night Blindness | <input type="checkbox"/> Sinus problems         | <input type="checkbox"/> Macular degeneration    |
- Headaches (where and when)? \_\_\_\_\_
- Any other head or neck problems? \_\_\_\_\_

## **CARDIOVASCULAR**

- |  |   |  |
|--|---|--|
| <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Dizziness          | <input type="checkbox"/> Swelling of feet        |
| <input type="checkbox"/> Low blood pressure  | <input type="checkbox"/> Fainting           | <input type="checkbox"/> Blood clot              |
| <input type="checkbox"/> Chest pain          | <input type="checkbox"/> Cold hands or feet | <input type="checkbox"/> Phlebitis               |
| <input type="checkbox"/> Irregular heartbeat | <input type="checkbox"/> Swelling of hands  | <input type="checkbox"/> Difficulty in breathing |
- Any other heart or blood vessel problems? \_\_\_\_\_

## **RESPIRATORY**

- |   |                                     |  |
|---|-------------------------------------|--|
| <input type="checkbox"/> Cough          | <input type="checkbox"/> Bronchitis | <input type="checkbox"/> Pain with deep breath |
| <input type="checkbox"/> Coughing blood | <input type="checkbox"/> Pneumonia  | <input type="checkbox"/> Asthma                |
- Difficulty in breathing when lying down
- Production of phlegm (what colour)? \_\_\_\_\_
- Any other lung problems? \_\_\_\_\_

## **GASTROINTESTINAL**

- |                                       |  |   |
|---------------------------------------|--|---|
| <input type="checkbox"/> Nausea       | <input type="checkbox"/> Blood in stools | <input type="checkbox"/> Hemorrhoids          |
| <input type="checkbox"/> Indigestion  | <input type="checkbox"/> Constipation    | <input type="checkbox"/> Abdominal pain       |
| <input type="checkbox"/> Black stools | <input type="checkbox"/> Gas             | <input type="checkbox"/> Itchy rectum         |
| <input type="checkbox"/> Vomiting     | <input type="checkbox"/> Rectal pain     | <input type="checkbox"/> Chronic laxative use |
| <input type="checkbox"/> Belching     | <input type="checkbox"/> Diarrhea        | <input type="checkbox"/> Bad breath           |
- Any other problems with your stomach or intestines? \_\_\_\_\_

## **GENITO-URINARY**

- |   |   |  |
|---|---|--|
| <input type="checkbox"/> Pain on urination  | <input type="checkbox"/> Unable to hold urine | <input type="checkbox"/> Recurrent UTIs    |
| <input type="checkbox"/> Freq. urination    | <input type="checkbox"/> Kidney stones        | <input type="checkbox"/> Sores on genitals |
| <input type="checkbox"/> Blood in urine     | <input type="checkbox"/> Decrease inflow      | <input type="checkbox"/> Yeast infections  |
| <input type="checkbox"/> Urgency to urinate | <input type="checkbox"/> Impotency            |  |
- Do you wake to urinate (how often)? \_\_\_\_\_
- Any particular colour to your urine? \_\_\_\_\_
- Any other problems with your genital or urinary system? \_\_\_\_\_

**PREGNANCY AND GYNECOLOGY - Women only**

Age at first menses \_\_\_\_\_ Length of cycle \_\_\_\_\_ Duration of menses \_\_\_\_\_

- Unusual menses
- Painful periods
- Clots
- Heavy
- Changes in body / psyche prior to menses \_\_\_\_\_
- Irregular periods
- Last PAP
- Vaginal discharge
- Vaginal sores
- Breast lumps

Do you practice birth control? Y /N

What type and for how long? \_\_\_\_\_

Could you be pregnant now? Y/N (circle Yes if it is possible)

1<sup>st</sup> day of last menses: \_\_\_\_\_

Number of pregnancies \_\_\_\_\_

These pregnancies resulted in:

Premature births: \_\_\_\_\_ Abortion: \_\_\_\_\_ Miscarriage: \_\_\_\_\_

Full term birth: \_\_\_\_\_ Postdate birth: \_\_\_\_\_

Any other obstetrical or gynecological issues? \_\_\_\_\_

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**MUSCULOSKELETAL**

- Neck pain
- Muscle pain
- Knee pain
- Back pain
- Muscle weakness
- Foot/ ankle pain
- Hand/ wrist pain
- Shoulder pain
- Any other joint or bone problems? \_\_\_\_\_

**NEUROPSYCHOLOGICAL**

- Seizures
- Dizziness
- Loss of balance
- Numb regions
- Easily susceptible to stress
- Have you ever been treated for emotional problems? Y / N
- Have you ever considered or attempted suicide? Y / N
- Any other neurological or psychological problems?
- Lack of coordination
- Poor memory
- Concussion
- Depression
- Anxiety
- Quick temper
- Irritable

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**COMMENTS**

Please indicate any other concerns you would like to discuss:

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### **CONSENT TO TREATMENT**

As part of your care under a Naturopathic Doctor, the following procedures may be done: health interview, physical exams, blood, urine or other laboratory procedures to assess your health status. Treatments may include nutritional supplementation, dietary counseling, acupuncture, craniosacral therapy, intravenous therapies, homeopathic remedies, and botanical remedies.

I, \_\_\_\_\_, as a patient of Banff Naturopathic Medical Clinic, have read the above information and understand that my care will reflect the philosophy and practices of Naturopathic Medicine. I recognize that there is a potential for any therapy to have complications in certain physiological conditions, or certain patients. The information I have provided is complete and inclusive of all health concerns including risk of pregnancy, and all medications including over the counter drugs. The slight health risks of some Naturopathic treatments include, but are not limited to: aggravation of pre-existing symptoms; allergic reactions to nutritional supplements, herbs or intravenous solutions; and fainting, bruising, or injury from acupuncture and venipuncture. I also recognize the following:

- I understand that a medical file will be kept of my visits. This record will be kept confidential as per the clinic privacy policy, and will not be released without my consent.
- I am aware that I am responsible for payment at the time services are rendered
- I am aware that I must cancel appointments by 11:30 am the day before my scheduled appointment to avoid a \$25 cancellation fee. Exceptions will be made for medical or family emergencies.
- I understand that Dr. Frey reserves the right to determine which cases fall outside of her scope of practice, in which event the appropriate referral will be recommended.

Signature \_\_\_\_\_ Date (m/d/y): \_\_\_\_\_  
(Parent or guardian to sign for patients under 18 years of age.)