the IV health centre

Naturopathic Intake Form

Today's Date _____

Name _____ Date of Birth (M/D/Y) _____

Address _____ City _____

Postal Code _____ Phone _____

Email _____ Occupation _____

Family Doctor _____ Phone _____

Emergency Contact _____ Phone _____

Height (ft) _____ Weight (lbs) _____ Blood Type _____

Note: By providing your email address you are giving us consent to send you email confirmations for your appointments as well as The IV health centre's specials and newsletter.

Are you currently seeing any other health care providers? (i.e. Other Naturopathic Doctors, Chiropractors, Acupuncturist, Massage Therapists, etc.) If so, please list below:

_____

How did you hear about the IV? ○ IV Website ○ Instagram ○ Facebook ○ Radio ○ Google ○ Family / Friend ○ Special Event ○ Other: _____

How did you hear about your Practitioner? ○ Website ○ Instagram ○ Facebook ○ Family / Friend ○ Referral - If so, who referred you: _____

Would you like to receive our newsletter for the latest news and features? ○ Yes ○ No

Health Information

List your health concerns (physical, emotional, or psychological) in order of importance to you, and the date your symptoms began:

1. _____ Date _____
2. _____ Date _____
3. _____ Date _____

What do you believe is causing your most important health concern?

_____

_____

What treatments have you tried for your health concerns and did they help?

_____

_____

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Allergies and Sensitivities

List all allergies to medications, environment, and food:

_____

_____

Supplements and Medications

List all that you are currently taking and for how long:

_____

_____

Medical History

List any condition that you have been diagnosed with and date of diagnosis:

_____

_____

List any diagnostic tests performed (blood sugar test, cholesterol, food sensitivity, etc.):

_____

_____

Family History

Indicate whether any family members have had any of the following:

	Relation To You		Relation To You
Alcoholism ○ Yes / ○ No		Diabetes ○ Yes / ○ No	
Allergies ○ Yes / ○ No		Drug Abuse ○ Yes / ○ No	
Alzheimer's Disease ○ Yes / ○ No		Heart Disease ○ Yes / ○ No	
Arthritis ○ Yes / ○ No		High Blood Pressure ○ Yes / ○ No	
Asthma ○ Yes / ○ No		Kidney Disease ○ Yes / ○ No	
Cancer (indicate type) ○ Yes / ○ No		Osteoporosis ○ Yes / ○ No	
Depression ○ Yes / ○ No		Stroke ○ Yes / ○ No	
Other Illnesses ○ Yes / ○ No		Other Illnesses ○ Yes / ○ No	

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Digestive Health

Do you experience any of the following regarding your bowel movements?

- Loose stools
- Hard stools
- Thin stools
- Constipation
- Blood in stools
- Dark stools
- Undigested food in stools
- Mucous in stools

Do you experience any of the following digestive symptoms?

- Bloating
- Flatulence
- Belching
- Heartburn/reflux
- Excess fullness after meals
- Abdominal cramping/pain
- Nausea
- Vomiting
- Haemorrhoids
- Anal fissures
- History of food poisoning/parasites

Do you currently or have you experienced any of the following?

- Frequent dieting
- Binge eating
- Poor appetite
- Always hungry
- Can't gain weight
- Can't lose weight
- Emotional eater
- History of bulimia/anorexia

How many cups of water do you drink per day? (including decaffeinated teas)

- 1-3 cups
- 4-7 cups
- 8 or more

Nutritional Health

Are you sensitive to any of the following foods?

- Dairy
- Sugar
- Alcohol
- Red meats
- Greasy foods
- Garlic/onions
- Carbohydrates (breads, pastas, pastries)
- Beans (chickpeas, lentils, etc.)
- Cruciferous vegetables (broccoli, cauliflower, asparagus etc.)

Do you crave any of the following foods?

- Sugar
- Chocolate
- Carbohydrates
- Salt
- Other _____

Immune System Health

Vaginal or C-section birth? (circle one)

How many rounds of antibiotics have you been on: Before puberty? _____

In the last 5 years? _____

Do you experience any of the following?

- Frequent cold/flues
- History of chronic viral infection (mono, herpes, shingles, hepatitis, HIV etc.)
- Urinary tract infections
- Sexually transmitted infections
- Yeast infection (toenail fungus/athlete's foot, vaginal/jock itch, tinea, etc.)
- Other infections (sinus, ear, lung, skin, bladder, kidney)
- Slow wound healing
- Strong body odour

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Nose / Throat / Respiratory Health

- Pneumonia/bronchitis
- Asthma
- Nasal congestion/phlegm
- Snoring/sleep apnea
- Bad breath/bad taste in mouth
- Enlarged lymph nodes
- Cold sores
- Canker sores
- Receding gums

Skin / Hair / Nails

- Dandruff
- Itchy ears
- Dry skin
- Oily skin
- Cellulite
- Acne
- Eczema
- Psoriasis
- Hives
- Bump on back of arms
- White coat on tongue
- Lack of sweating
- Sweating easily
- Dark circles under eyes
- Soft or brittle nails
- Ridging or spots on nails
- Hair loss or breaking

Urinary Health

- Frequent urination
- Incontinence/dribbling
- Blood in urine
- Discomfort on urination
- Kidney stones

Cardiovascular / Circulatory Health

- Chest pain/angina
- Heart palpitations
- Easy bruising
- High blood pressure
- Low blood pressure
- Varicose veins
- Cold hands/feet

Eyes / Ears

- Eye strain
- Itchy/watery eyes
- Changes in vision
- Ears buzzing/ringing

Musculoskeletal Health

- Tension headaches
- Migraines
- TMJ problems
- Low back pain
- Foot cramps/pain
- Muscle spasms/cramps
- Muscle weakness
- Joint pain/stiffness
- Arthritis
- History of physical trauma (broken bones, falls, car accidents, etc)

Hormone System Health

- Cold intolerance
- Heat intolerance
- Recent weight change
- Night sweats

Sleep / Energy

How many hours average do you sleep per night? _____

Do you experience any of the following?

- Difficulty falling asleep
- Difficulty staying asleep
- Tired upon waking
- Caffeine dependency
- Exercise intolerance
- Dizziness standing up

Rate your average energy between 1 and 10

(low) 1 2 3 4 5 6 7 8 9 10 (high)

How many times do you exercise per week?

- 1-2 times
- 3-4 times
- 5-6 times
- 7 or more

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Mental / Neurological Health

- ○ Anxiety
- ○ Panic attacks
- ○ Depression
- ○ Irritability
- ○ Poor memory
- ○ Difficulty concentrating
- ○ Chronic worry
- ○ Dizziness/vertigo
- ○ Lightheaded/fainting
- ○ Tremor/trembling
- ○ History of mental/emotional trauma
- ○ History head injury/concussion or other physical trauma

Have you received counselling? ○ Yes ○ No

Relationship status:

- ○ Married
- ○ Partnership
- ○ Separated
- ○ Widowed
- ○ Divorced
- ○ Single

Who do you live with?_____

Occupation: _____

Do you enjoy your work? ○ Yes ○ No

How many hours per week do you work?____

Rate your stress between 1 and 10

(low) 1 2 3 4 5 6 7 8 9 10 (high)

What are your main stressors? _____

_____

_____

What are your hobbies? _____

_____

_____

Lifestyle History

How many of the following do you have per day or week? (indicate which & if past history)

Caffeine _____
Alcohol _____
Tobacco _____
Recreational Drugs _____

Male Reproductive Health

- ○ Erectile dysfunction
- ○ Low libido
- ○ Testicular mass/pain
- ○ Discharge/sores
- ○ Urinary urgency
- ○ Urinary hesitancy
- ○ Prostate problems
- ○ Difficulty gaining muscle mass

Menstrual Health

(if menopausal, fill out based on history)

Age of 1st period: _____

Are you sexually active? ○ Yes ○ No

Do you struggle with low libido? ○ Yes ○ No

Are you currently on birth control?

○ Yes ○ No

Do you experience any of the following symptoms with your period?

- ○ Irregular cycles
- ○ Heavy bleeding
- ○ Bleeding between periods
- ○ Painful cramps with menses
- ○ Clots in menstrual blood
- ○ Dark/purple menstrual blood

PMS Symptoms (symptoms before period starts)

- ○ Breast tenderness
- ○ Bloating
- ○ Water retention
- ○ Mood changes
- ○ Acne
- ○ Cravings
- ○ Headaches/migraines
- ○ Cramping

When do PMS symptoms begin?

_____ days before period begins

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Additional Information

What would you like to gain from today's visit?

_____

_____

_____

What therapies are you interested in exploring, circle or state if not listed?

○ Nutrition Support ○ Supplements ○ Herbs ○ IV Therapy ○ Acupuncture ○ Cupping
○ Aesthetics ○ Other (please specify) _____

What behaviours of lifestyle habits do you currently engage in regularly that you believe support your health? _____

_____

What behaviours of lifestyle habits do you currently engage in regularly that you believe are harming your health? _____

_____

Who do you know that will sincerely and consistently support you with the beneficial lifestyle changes you will be making? _____

_____

Indicate on the figure below any areas of concern: