BETA
WELLNESS CENTRE

Short Intake Form

Name _____ **M** ◯ **F** ◯ **Today's Date (Mo/Day/Year)** _____/_____/____

Date of Birth (Mo/Day/Year) _____/_____/_____ **Care Card Number** _____

Home Address_____ **City**_____ **Postal Code**_____

Main Phone_____ **Alternative number** _____

Emergency Contact Name _____ **Relationship**_____ **Number**_____

EMAIL ADDRESS _____

☐ *Please email me about upcoming talks, featured services and products.* ☐ *Please use my email for Appointment Reminders*
☐ *Please use my phone number for Appointment Reminders*

How did you find us (friend/family member, our sign, our website, other)?_____

Occupation/Previous Occupation_____

Please ensure the information that you provide is accurate and complete. All information collected is considered confidential and is kept in accordance with the College of Naturopathic Physicians of BC.

HEALTH OBJECTIVES: ☐ Wellness/Prevention ☐ Please contact me for annual check-ups as well ☐ Complaint Oriented
☐ I am here for a predetermined reason only and forgo any visit with a doctor. (In this case you may skip all grey text.)

MAIN HEALTH CONCERNS With Date of Onset (list in order of importance)

_____
_____
_____
_____

Have you been given any diagnosis? If so, what?
_____
Have you had any lab work done or special studies e.g. x-ray, CT, MRI, EKG, EchoKG, angiogram, etc._____
What treatments have you tried and what were the outcomes_____
_____

ALLERGIES/SENSITIVITIES_____
MEDICATION/SUPPLEMENTS:_____
_____

YOUR MEDICAL HISTORY:

- ☐ Autoimmune Disease
- ☐ High/Low Blood Pressure
- ☐ Pregnant (or planning to be)
- ☐ Mental Illness
- ☐ Rheumatic Fever
- ☐ Tuberculosis
- ☐ Cancer
- ☐ Diabetes
- ☐ Kidney or bladder disease
- ☐ Thyroid disease
- ☐ Hepatitis
- ☐ Seizures
- ☐ Stroke
- ☐ Venereal Disease
- ☐ Other Conditions:

_____
_____
_____

☐ Exposure to harmful chemicals, radioactivity, fumes or other health hazards? Describe: _____

Any Hospitalizations, Surgeries, Implants etc. including date_____

Describe any significant stress in your life, e.g. schooling, residence, finances, relationships, etc._____

_____ _____
(Signature of Patient, Parent or Legal Guardian) (Date)