



E206 20159 88th Ave., Langley, BC V1M 0A4 • P: (604)881-7888 • F: (604)881-7889 • www.revivenaturopathic.com

PATIENT INTAKE FORM

Personal Information

(*all information in this form remains confidential and will be released only upon your written consent)

Last Name	First Name
Age	Gender M F
Date of Birth (mm/dd/yy) / /	Marital Status S M D W
Address	
City	Province
Postal Code	Email Address
Home Phone	Cell Phone
Occupation	Work Phone
Emergency Contact	Phone
Family Physician	Phone
How did you Hear about us?	

Please List all current health concerns in the order of importance

1.	4.
2.	5.
3.	6.

Medical History


- | | | |
|--|---|---|
| <input type="checkbox"/> Anemia | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> High Blood Pressure |
| <input type="checkbox"/> Hepatitis/Liver Disease | <input type="checkbox"/> Kidney Stones | <input type="checkbox"/> Pneumonia |
| <input type="checkbox"/> Hayfever | <input type="checkbox"/> Asthma | <input type="checkbox"/> Bladder/Vaginal Infection |
| <input type="checkbox"/> Tuberculosis | <input type="checkbox"/> Cancer of _____ | <input type="checkbox"/> Abnormal Pap Test |
| <input type="checkbox"/> Stomach Ulcers | <input type="checkbox"/> Migraine Headaches | <input type="checkbox"/> Prostate Problems |
| <input type="checkbox"/> Measles | <input type="checkbox"/> Mumps | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Colitis | <input type="checkbox"/> Arthritis/Rheumatism | <input type="checkbox"/> Mononucleosis |
| <input type="checkbox"/> Blood Clots | <input type="checkbox"/> Hives | <input type="checkbox"/> Sexually Transmitted Disease |
| <input type="checkbox"/> Gallbladder Problems | <input type="checkbox"/> Thyroid Problems | <input type="checkbox"/> Eczema |
| <input type="checkbox"/> Angina/Chest Pain | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Depression |
| <input type="checkbox"/> Polio | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Eating Disorder |
| <input type="checkbox"/> Stroke | <input type="checkbox"/> Alcohol/Drug Abuse | |
| <input type="checkbox"/> Epilepsy | <input type="checkbox"/> Mental Disorder | |
| <input type="checkbox"/> Smoker? (Y or N) | <input type="checkbox"/> Heart Attack | |





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 Surgeries or Hospitalizations (Year & Type)

Other Conditions _____

 Known Allergies (including medicines, pollens, animals, foods & Chemicals)

 Current Medications (including prescription & over the counter drugs, any supplements and herbs)

 Family Health History IDENTIFY ALL FAMILY MEMBERS WHO HAVE EVER HAD ANY OF THE FOLLOWING (INDICATE FAMILY MEMBER BY F for FATHER, M for MOTHER, B1, B2, S1, etc.)

- | | | |
|---|--|--|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Gallstones | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Arthritis | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Stomach Ulcer |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Bleeding Tendencies |
| <input type="checkbox"/> Cancer (type)_____ | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Other Medical |
| <input type="checkbox"/> Diabetes | <input type="checkbox"/> Gout | Conditions: |
| <input type="checkbox"/> Eczema | <input type="checkbox"/> Mental Illness | _____ |
| <input type="checkbox"/> Endometriosis | <input type="checkbox"/> Multiple Sclerosis | |

 Lifestyle (frequency and types)

- Alcohol _____
- Caffeine _____
- Water _____
- Cigarettes _____
- Recreational Drugs _____
- Exercise _____

 Women Only

- Number of children ____Ages_____
- Number of Pregnancies ____Deliveries__
- Miscarriages ____ Accidental____
- Induced_____
- Complications_____
- Birth control Methods: In Past _____
- Now_____
- Are you pregnant at this time? _____



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What expectations do you have from working with our clinic?

Consent and Cancellation Policy

I, _____ hereby consent to receive treatment by the practitioners of Revive Naturopathic Health Clinic. I understand that I am responsible for paying the full cost of treatment at the time of appointment; including fees for the services, prescriptions, and laboratory tests. I understand that 24 hours notice is required for appointment cancellation; otherwise I will be responsible for the cancellation fee of \$30.

Signature: _____ Date: _____

Thank you for your time in filling out this information.

We look forward to providing you with the highest quality of care.