revive
NATUROPATHIC HEALTH CLINIC
18838 – 68th Ave, Surrey • P: 604-576-5889 • 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 ☑

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

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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.)

- ☐ Allergies
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer (type)_____
- ☐ Diabetes
- ☐ Eczema
- ☐ Endometriosis
- ☐ Gallstones
- ☐ Heart Disease
- ☐ High Blood Pressure
- ☐ Kidney Disease
- ☐ Gout
- ☐ Mental Illness
- ☐ Multiple Sclerosis
- ☐ Osteoporosis
- ☐ Stomach Ulcer
- ☐ Bleeding Tendencies
- ☐ Other Medical Conditions: _____

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.