Apple Naturopathic Clinic
Dr. Erika Kneeland, ND
#108-2100 Guthrie Rd.
Comox, BC V9M 3P6
Applenaturopathic.com

New Patient Intake Form

Name: _____

Date of Birth: _____

Are you familiar with naturopathic medicine? _____

Main reason(s) for attending the clinic, in order of importance. Indicate when the symptoms first appeared.

_____

_____

_____

_____

_____

Medical doctor's name: _____

Do you consult with other health care professionals? Please list

_____

For women only:

Date of last PAP test? _____
(This screening is offered through Dr. Kneeland)

Age of first menses: _____

If over 40, date of last mammogram? _____

Please list drugs/medications you are currently taking:

_____

_____

_____

Please list drugs/medications you were taking in the past:

_____

_____

Please list all supplements you are currently taking:

_____

_____

Do you wear a medic alert bracelet? Y N
Do you wear a pacemaker? Y N
Do you have any drug related allergies? Y N
Do you have any food/environmental allergies/ sensitivities? Y N (If yes, please list)

Which of the following conditions have you had? (please circle)
Alcoholism/Allergies/Anemia/Arthritis/Asthma/Cancer/Chicken pox/Cold sores/
Depression/Diabetes/Ear infections/Eczema/Emphysema/Epilepsy/Frequent colds/
Gall stones/Gonorrhea/Gout/Hay fever/Heart disease/Hepatitis/Herpes/Influenza/
Kidney disease/Leukemia/Malaria/Measles/Miscarriage/Mononucleosis/Mumps/
Parasites/Pelvic inflammatory disease/Peritonitis/Pleurisy/Pneumonia/Prostatitis/
Recurrent infections/Rheumatic fever/Rubella/Scarlet fever/Skin disease/Strep throat/
Sinusitis/Sunstroke/Thyroid disease/Tonsilitis/Tuberculosis/Warts/Whooping cough

Is there any of the preceding conditions after which you have never been totally well since or which have been more serious than usual?

_____

Please list any operations, hospitalizations, childbirths, major accidents or traumas you have had:

_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____
_____ Date: _____

Please indicate below which of the following conditions have affected your relatives
Indicate: F=Father, M=Mother, S1=Sibling, S2=Sibling etc., PGM=Paternal Grandmother, MGM=Maternal Grandmother, PA=Paternal Aunt, PU= Paternal Uncle

Alcoholism:
Allergies:
Arthritis:
Asthma:
Autoimmune disease:
Cancer (type):
Depression:
Diabetes:
Hay fever:
Heart disease:
High blood pressure:
Mental illness:
Osteoporosis:
Pneumonia:
Skin disease:
Thyroid disease:
Tuberculosis:
Gout:

Do you (please circle):
Smoke/Drink alcohol regularly/Drink coffee/Tea/Pop/Use recreational drugs/Use Antacids, Steroids or Laxatives

Have you lost any weight lately? How many pounds? _____

What exercise do you do and how much?

What are your short-term health goals?

_____

What are your long-term health goals?

_____