

ACUTE PATIENT INTAKE FORM

Name: _____ Date of Birth: _____

Address: _____

Home Phone: _____ Work Phone: _____

Occupation: _____ Employer: _____

Sex: M / F Marital Status: _____ # of Children: _____

Contact Person in case of Emergency: _____ Phone #: _____

Does your extended health care plan cover naturopathic services? Y / N

Date of last medical visit: _____ Reason: _____

Family physician: _____ Phone #: _____

Past injuries: _____ When? _____

_____ When? _____

Past surgeries: _____ When? _____

_____ When? _____

Allergies (please list):

What is your primary reason for visiting the doctor today?

Please list food supplements, vitamins, minerals, homeopathics, and herbs you currently take and indicate dosage:

_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list prescription and non-prescription medicines you currently take and indicate dosage:

_____	_____	_____
_____	_____	_____
_____	_____	_____
