



# CANTADORA

Naturopathic Healthcare Centre

## INTAKE FORM

### CONTACT INFORMATION

Name \_\_\_\_\_ Age \_\_\_\_\_ Birthdate(D/M/Y) \_\_\_\_\_

Address \_\_\_\_\_ City \_\_\_\_\_ Postal Code \_\_\_\_\_

Phone (Home) \_\_\_\_\_ (Work) \_\_\_\_\_ (Cell) \_\_\_\_\_

Is it okay to leave a message? Yes/No Email \_\_\_\_\_

Emergency Contact \_\_\_\_\_ Contact Number \_\_\_\_\_

Occupation \_\_\_\_\_

Physician Name \_\_\_\_\_ Physician Number \_\_\_\_\_

Last physician or health practitioner seen? \_\_\_\_\_ When? \_\_\_\_\_

How did you find out about our office? \_\_\_\_\_

### YOUR CURRENT HEALTH CONCERNS

What is your main reason for coming in today? \_\_\_\_\_  
\_\_\_\_\_

Please list, in order of importance, any other health concerns that you may have:

1. \_\_\_\_\_
2. \_\_\_\_\_
3. \_\_\_\_\_
4. \_\_\_\_\_

What kind of treatment have you received for the above? \_\_\_\_\_

Which of the following do you currently use? Please indicate how much, how often and for how long.

Alcohol		Tobacco	
Hormones		Coffee	
Cortisone		Laxatives	
Sedatives		Antacids	
Recreational drugs		Aspirin or Tylenol	





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Have you had any major injuries? If so, what happened and when?

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Please list any previous surgeries and hospitalizations including dates.

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Were you vaccinated? Yes/No      Any adverse reactions (e.g. fever, skin rash, etc.) Yes/No

### FAMILY HEALTH HISTORY

	Mother	Father	Sibling	Grandparent	Other blood relative
Cancer (type)					
Drug Abuse/Alcoholism					
Heart disease					
Arthritis					
Diabetes					
High blood pressure					
Asthma					
Kidney disease					
Depression					
Anemia					
Mental Illness					
Other					

### LIFESTYLE

Are you currently living with:    Spouse    Partner    Parents    Friends    Children    Alone

How many children do you have? (names and ages)    \_\_\_\_\_

Do you exercise? Yes/No    If yes, what and how often? \_\_\_\_\_

What is your current level of stress?    Very High    High    Moderate    Low    None

How much sleep on average do you get each night? \_\_\_\_\_ Hrs

Any sleep difficulties? \_\_\_\_\_

On a scale of 1-10, how would you rate the quality of your sleep (10 being great)? \_\_\_\_\_

How is your body temperature, compared to others?    Warmer    Cooler    Average

Do you enjoy your work?    Yes/No

Is there anything else you feel is relevant that I should know about you?

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Thank you for taking the time to fill out this lengthy questionnaire!  
It will be a valuable resource in helping to understand your health.  
Looking forward to working with you to achieve your goals.