cornerstone naturopathic inc.

14 Old School Road
Upper Tantallon NS, B3Z 2J6

(902) 820-3443
(902) 820-3440

Adult Intake Form

Name _____ **Date** _____

Date of Birth _____ **(M/D/Y)** **Sex: M ❑ / F ❑**

Address _____

Email address _____

Telephone: Home _____ **Work** _____

May we leave messages relating to your visits? Y ❑ / N ❑ **Which phone number?** _____

Emergency Contact: Name _____ **Phone** _____

Relation _____

How did you hear about our Dr. MacLeod? Please check one of the following:

❑ **Friend/Family**
❑ **Referral Within This Clinic**
❑ **Internet**
❑ **Print advertisement**
❑ **Health/Wellness Event**
Other _____

Other healthcare providers that you are seeing:

Name_____	**Name**_____	**Name**_____
Address	**Address**	**Address**
_____	_____	_____
_____	_____	_____
_____	_____	_____
Phone _____	**Phone** _____	**Phone** _____
Fax_____	**Fax**_____	**Fax**_____

What are your health concerns, in order of importance to you?

1. _____
2. _____
3. _____
4. _____
5. _____

How would you describe your general health? Excellent ❑ Good ❑ Fair ❑ Poor ❑

Do you get regular screening tests done by another doctor? (pap, blood tests, etc.)? Y ❑ / N ❑

Please indicate any serious conditions, illness or injuries, along with approximate dates:

_____

_____

_____

Indicate if a close relative (parent, child, sibling) has had any of the following:

	Please indicate which family member
Allergies	
Asthma	
Heart Disease / Stroke	
High Blood Pressure	
Cancer	
Diabetes	
Depression	
Other Mental Illness	
Drug Abuse/Alcoholism	
Kidney Disease	
Other	

Occupation: _____

Hobbies: _____

Please list all current medications (prescription, over the counter, vitamins, herbs, etc.)

_____ _____

_____ _____

_____ _____

_____ _____

Alcohol- how much/day or week _____

Tobacco- form and amount/day _____

Caffeine- form and amount/day _____

Recreational drugs- what and how often _____

---For the following please print and sign or email and sign in-office---

Consent to share information with family physician:

I grant my permission to Dr. Colin MacLeod to share my confidential health information with my family doctor as necessary.
Signature: _____ **Date:** _____

Consent to treatment:

- **I understand that: as a naturopathic doctor, Dr. Colin MacLeod does not guarantee treatment results.**
- **Dr. MacLeod will explain to me the nature of the treatment provided and will answer any questions I have.**
- **I am free to withdraw my consent and discontinue treatment at any time.**

Signature: _____ **Date:** _____