Dr. Ali McMillan
NATUROPATHIC DOCTOR

Patient Intake Forms

Please fill in all the information as accurately as possible. The information you provide will assist in formulating a complete health profile. All answers are confidential.

PATIENT INFORMATION

Name: First | Middle | Last

Date of Birth: | Gender/Sex[1]:

Guardian Name (if applicable): | Relationship:

Address: | City:

Prov: BC | Postal Code: | Phone: ( ) - | Home

Email Address: | Pronouns:

EMERGENCY CONTACT

Name | Relationship

Home Phone ( ) - | Cell ( ) - | Work ( ) -

REFERRALS AND ADJUNCTIVE CARE

Are you currently under medical care? Yes | Primary Care Physician:

When did you last see a doctor?: | What are you being treated for?:

When was your last blood test and what was it for?:

HEALTH CONCERNS/SYMPTOMS

Describe your main health concerns:

1 Don't want to answer this question on this form? No problem! Leave it blank and Dr. McMillan is happy to explain what she needs to know to deliver the best care for you and why she needs to know certain things.

TREATMENT GOALS

What are your short term treatment goals?

1.
2.
3.

What are your long term treatment goals?

1.
2.
3.

PAST AND CURRENT MEDICAL HISTORY

List any accidents, injuries and hospitalizations (include type and year of occurrence):

List any know allergies (including food, drug, herb, environmental, etc):

Please indicate if you currently/previously have been diagnosed with any of the following:

- ☐ Abscess
- ☐ Anemia
- ☐ Anxiety
- ☐ Arthritis
- ☐ Asthma
- ☐ Cancer
  Type:_____
- ☐ Chicken pox
- ☐ Cold sores
- ☐ Depression
- ☐ Eczema
- ☐ Emphysema
- ☐ Epilepsy
- ☐ Fibrocystic breast disease
- ☐ Frequent colds
- ☐ Gallstones
- ☐ Genital herpes
- ☐ Genital warts
- ☐ Gonorrhea
- ☐ Gout
- ☐ Hay fever
- ☐ Headaches
- ☐ Heart disease
- ☐ HIV
- ☐ Kidney disease
- ☐ Leukemia
- ☐ Low blood pressure
- ☐ High blood pressure
- ☐ Malaria
- ☐ Measles
- ☐ Menstrual cramps
- ☐ Mono
- ☐ Multiple sclerosis
- ☐ Mumps
- ☐ Parasites
- ☐ Peritonitis
- ☐ Pelvic inflammatory disease
- ☐ Pleurisy
- ☐ PMS
- ☐ Pneumonia
- ☐ Prostatitis
- ☐ Psoriasis
- ☐ Rheumatic fever
- ☐ Rubella
- ☐ Scarlet fever
- ☐ Stroke
- ☐ Strep throat
- ☐ Syphilis
- ☐ Tonsillitis
- ☐ Tuberculosis
- ☐ Warts
- ☐ Whooping cough
- ☐ Intestinal worms

Others:

Recent Screening tests (include year and results):

What is your: Height? Weight? Any recent weight change?

DIET, SUPPLEMENTS, MEDICATIONS

Please list all medications you are currently taking including frequency and dose.

Please list all natural health products you are currently taking?

I would describe my diet as:

Do you regularly cook your own meals?:

Do you eat take out/at restaurants? <1 time per week Junk food? <1 time per week

LIFESTYLE

How is your sleep?:

When do you typically wake up? When do you typically go to bed?

Do you stay consistent with these times? Do you work night shifts?

Do you have trouble falling asleep? Do you have trouble staying asleep?

Do you exercise? If yes, what type, frequency:

Do you use tobacco products? Are you exposed to secondhand smoke?

Do you use alcohol or recreational drugs and if so, what type?

Do you experience a lot of stress? If you work, occupation?

Family History

Indicate below any health conditions that have affected members of your family:

Parent 1	Grandparent 1
Parent 2	Grandparent 2
Siblings	Grandparent 3
Children	Grandparent 4