Dr. Marie-Jasmine Parsi
Naturopathic Doctor

# Adult Patient Information Form

| Patient Information | | | |
|---|---|---|---|
| Last Name: | First Name: | Middle Name: | |
| Date of Birth (MM/DD/YYYY): | Age: | Sex: F ☐ M ☐ | Occupation: |
| **Contact Information** | | | |
| Full Address: | | City, Province: | |
| Postal Code: | Daytime phone number: | Evening phone number: | May we leave messages regarding your visit? Y ☐ N ☐ |
| Email: | | | |
| **Emergency Contact Information** | | | |
| 1) Last Name: | First Name: | Relationship: | |
| Daytime phone number: | | Evening phone number: | |
| 2) Last Name: | First Name: | Relationship: | |
| Daytime phone number: | | Evening phone number: | |
| **Other Healthcare Providers** | | | |
| Name: | Name: | Name: | |
| Speciality/Focus: | Speciality/Focus: | Speciality/Focus: | |
| Phone number: | Phone number: | Phone number: | |
| Date of last medical doctor visit: | | Date of last physical exam: | |
| Please list regular screening tests performed by other physicians: | | | |

| | |
|---|---|
| How did you hear about this clinic? | |
| If referred, please state by whom: | |
| Have you been treated by a Naturopathic Doctor before? Yes ☐ No ☐ | |
| If yes, by whom? | Date of last visit to ND: |

# Health Assessment Questionnaire

| What health concerns would you like to address? |
|---|
| 1) |
| 2) |
| 3) |
| 4) |
| 5) |

| Medical History | | | |
|---|---|---|---|
| If you are a female, are you pregnant?<br>Yes ☐ No ☐ | | Are you trying to become pregnant?<br>Yes ☐ No ☐ | |
| Height: | Current Weight: | Past min. weight: | Past max. weight: |
| Which of the following childhood illnesses have you had: Check all that apply:<br>☐ Asthma ☐ Polio ☐ Mumps<br>☐ Rheumatic fever ☐ Scarlet fever ☐ Roseola<br>☐ Rubella ☐ Whooping cough ☐ Measles<br>☐ Chicken pox | | | |

| List any **previously diagnosed medical conditions**: | **Treatment received**: | **Year**: |
|---|---|---|
| 1) | | |
| 2) | | |
| 3) | | |
| 4) | | |

| **List all allergies**<br>(medications, foods, supplements, environmental, etc) | **Reaction type**: |
|---|---|
| 1) | |
| 2) | |
| 3) | |

| List all **prescription drugs** (i.e. oral contraceptive, etc.) **over-the-counter medications** (i.e. pain killers, antacid, etc.) **herbs and natural supplements** (i.e. vitamins, fish oil, etc.) that you are currently taking: | | |
|---|---|---|
| **Medication** | **Dosage** | **Start Date** |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |
| | | |

| **Family Medical History** | | | | | |
|---|---|---|---|---|---|
| Include: heart disease, high blood pressure, cancer, diabetes, depression and other mental illness, drug and alcohol abuse, kidney disease, arthritis, infertility, headaches, neurological conditions, hyper/hypothyroid and other relevant information. | | | | | |
| | Age | Health History | | Age | Health History |
| **Father** | | | **Mother** | | |
| **Grandmother (maternal)** | | | **Grandmother (paternal)** | | |
| **Grandfather (maternal)** | | | **Grandfather (paternal)** | | |
| **Siblings** | | ☐F ☐M | **Children** | | ☐F ☐M |
| | | ☐F ☐M | | | ☐F ☐M |
| | | ☐F ☐M | | | ☐F ☐M |
| | | ☐F ☐M | | | ☐F ☐M |

| Dietary and Lifestyle Habits | | | |
|---|---|---|---|
| **Exercise** | How many times do you exercise per week?<br>Never ☐ 1x ☐ 2x ☐ 3x ☐ 4x ☐ 5x ☐ >5x ☐<br>For how long?<br>0-15min ☐ 15-30min ☐ 30-60min ☐ >60min | | |
| | What type of exercise?<br>Strength ☐ Describe:<br>Aerobic/Cardio☐ Describe:<br>Flexibility☐ Describe: | | |
| **Diet** | Are you currently dieting?<br>Yes ☐ No ☐ | Is it a physician-prescribed diet?<br>Yes ☐ No ☐ | |
| | Do you have any dietary restrictions? | | |
| **Caffeine** | # cups of the following consumed in a day:<br>Coffee: # | Tea: # | Cola: # |
| **Alcohol** | Do you consume alcohol?<br>Yes ☐ No ☐ | If yes, how many drinks/week? | |
| | What type of alcohol do you consume? | | |
| **Tobacco** | Do you use tobacco? Yes ☐ No ☐ | If yes, how many/day? | |
| | What type(s) of tobacco? | How many years? | |
| | Are you exposed to second hand smoke? Yes ☐ No ☐ | | |
| **Sleep** | On average how many hours of sleep do you get per night?<br>Do you feel rested upon waking? Yes ☐ No ☐ | | |
| | Do you have trouble falling asleep? Yes ☐ No ☐ | | |
| | Do you wake up during the night? Yes ☐ No ☐<br>If yes, how many times/night? | | |
| **Energy** | On a scale of 1 (lowest) to 10 (highest), rate your energy level: | | |
| **Stress** | What are some stressors in your life? | | |
| **Toxins** | Are you regularly exposed to any toxins or other hazards?<br>Please specify: | | |

Is there any other important information that you would like me to know?

| |
|---|
| |