MICHELLE LENA WELLNESS

MICHELLE STHAMANN, ND

CATHEDRAL WELLNESS

PLEASE COMPLETE THIS FORM AND RETURN IT TO CLINIC RECEPTION

(Please print clearly)

Adult Intake

(Please print clearly)

Would you like to receive our newsletter? Yes or No

Contact Information

Name: _____

Date: _____

Date of birth: _____ (M/D/Y)

Preferred Pronoun: He She other_____

Address:_____

Apt/unit#:_____

City: _____ Province: _____ Postal Code:_____

E-mail: _____

Address:_____

Telephone number: Home:_____ Work:_____ Cell:_____

May we leave messages relating to your visits? Y / N

Which Phone #: _____

Emergency contact

Name: _____

Phone number(s):_(_____)_____ or_(_____)_____

Relation:_____

How did you hear about our Clinic? Please check one of the following:

A patient of the clinic (please provide name): _____

My medical doctor/Specialist (please provide name): _____

Other Health Care Provider (please provide name):_____

___ Advertising (newspaper, TTC, brochure), Social Media (Facebook, Twitter etc.)

___ Business Cards from Another Business (Dad's Organic Market, Oxygen fitness…etc)

___ Information Session

___ Other: _____

How would you identify your gender identity (please check all appropriate boxes):
__ Female ___ Male ___ Transgender _____ Alternative: _____ Prefer not to answer

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<u>Other health care providers you are seeing:</u>

Name:_____

Specialty:_____

Phone #: (_____)_____

Date of last visit: _____

Name:_____

Specialty:_____

Phone #: (_____)_____

Date of last visit: _____

Name:_____

Specialty:_____

Phone #: (_____)_____

Date of last visit: _____

Have you ever consulted (Please check all that apply):

__ Naturopathic doctor __Acupuncturist __Nutritionist __Counselor

Medical history

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

Please indicate any serious conditions, illnesses or injuries, and any hospitalizations; along with approximate dates.

1) _____

2) _____

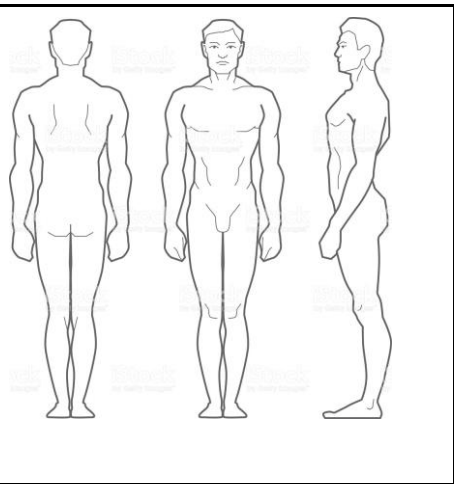
3) _____

4) _____

5) _____

6) _____

Please list most important health concerns and goals in their order of signifi-cance:	Prior diagnosis of this problem? If so, what?	

1		
2		
3		
4		
5		

Do you have any allergies (medicines, environmental, etc.)?

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Please list all current medications/natural health products (prescription, over-the-counter, vitamins, herbs, homeopathics, etc.)

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Please list past prescription medications/natural health products:

_____

_____

_____

Please circle Yes (Y), No (N) or Past (P) regarding use of the following:

Diet pills Y N P

Antacids Y N P

Pills / Implants / Injections Y N P

Aspirin, Tylenol, Advil or other pain relievers Y N P

Laxatives Y N P

Birth control Y N P

Antibiotics Y N P

Alcohol—how much/day or week: _____

Approximate number of prescriptions: _____

Tobacco—form and amount/day _____

Caffeine—form and amount/day _____

Recreational drugs—what and how often_____

Are you currently pregnant? Yes No (Please circle one) Due date_____

Are you currently lactating? Yes No (Please circle one)

Please indicate what immunizations you have had:

DPT (diphtheria, pertussis, tetanus) ___ Haemophilus influenza B_____ Hepatitis A ———————-Tetanus booster; when?_____ "Flu"_____

Hepatitis B _____MMR (measles, mumps, rubella)_____
Polio_____Smallpox_____Other_____

Please indicate if any caused adverse reactions: _____

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

Last time you had blood work done_____

Personal and Family History

Please check the "yes" box next to each condition that applies to you and/or one of your family members. Please circle all who the condition applies to: "**Self**" if it relates to you and/or Father (**F**), mother (**M**), sibling (**S**), Grandparent (**G**), your child (**C**). Please circle **Past** if the condition is resolved, or **Current** if it is on-going and current

	Yes (✓)	Relation Please circle	Dates Resolved		Yes (✓)	Relation Please circle	Dates Resolved
Alcoholism/Drug addiction		Self FMSGC	Past Current	High Blood pressure		Self FMSGC	Past Current
Allergies		Self FMSGC	Past Current	Heart Disease		Self FMSGC	Past Current
Anemia		Self FMSGC	Past Current	Hepatitis		Self FMSGC	Past Current
Arthritis		Self FMSGC	Past Current	Headaches		Self FMSGC	Past Current
Asthma		Self FMSGC	Past Current	Kidney disease		Self FMSGC	Past Current
Cancer		Self FMSGC	Past Current	Stroke		Self FMSGC	Past Current
Diabetes		Self FMSGC	Past Current	Tuberculosis		Self FMSGC	Past Current

Eczema		Self FMSGC	Past Current	Osteoporosis		Self FMSGC	Past Current
Epilepsy		Self FMSGC	Past Current	Others:		Self FMSGC	Past Current
Depression/other Mental Illness		Self FMSGC	Past Current				

_____ I don't know my family medical history

Routine Medical Testing

Female Only

Date last PAP _____
Date last Mammogram _____

Date last Period Began _____

Age 1st period _____

Any other testing? If yes, please explain: _____

Male Only

Date last colonoscopy _____

Date of last fecal occult blood test (FOBT) _____

Date of last prostate exam _____

Any other testing? If yes, please explain: _____

Diet

Do you have any food allergies or intolerances? Please list.

1) _____

2) _____

3) _____

4) _____

5) _____

6) _____

Do you have any dietary restrictions (religious, vegetarian/vegan, etc.)?
_____

Environment/Social History

Occupation _____

Hobbies _____

Do you exercise regularly? Y / N What do you do for exercise, how much, how often?
_____
_____
_____

Are you exposed to significant tobacco smoke (work, home, etc.)? Y / N

Are you frequently exposed to animals (work, pets, etc.)? Y / N

How is your home
heated?_____

Are you regularly or have you ever been regularly exposed to solvents, heavy metals, fumes pesticides/herbicides or other toxic materials (work, home, hobbies, etc.)? Please de-
scribe:_____
_____
_____

Are you particularly sensitive to perfumes, gasoline or other vapours (such as from new furniture, carpets, paints etc)?
_____

How would you describe the emotional climate of your home?

_____
_____

How stressful is your work, or other aspects of your life? How well do you handle these stresses

_____
_____
_____

Is there anything that you feel is important that has not been covered?

_____
_____**Ot**

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What are your health concerns and goals, in order of importance to you:

1) _____

2) _____

3) _____

What three expectations do you have from this visit to our clinic?

1. _____

2. _____

3. _____

What long-term expectations do you have from working with our clinic?

_____

_____

What expectations do you have of me personally as your physician?

_____

_____

What is your present level of commitment to address any underlying causes of your signs and symptoms that relate to your lifestyle? (Rate from 0 to 10, 10 being 100% committed)

1 2 3 4 5 6 7 8 9 10

What behaviours or lifestyle habits do you currently engage in regularly that you believe support your health? (Please list)

_____

_____

What behaviours or lifestyle habits do you currently engage in regularly that you believe are self-destructive lifestyle habits? (Please list)

_____

_____

What potential obstacles do you foresee in addressing the lifestyle factors, which are undermining your health, and in adhering to the therapeutic protocols that we will be sharing with you?

_____

_____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes you will be making?

_____

_____

What do you LOVE to do?

_____

_____

Thank you for filling out this comprehensive intake form. I look forward to working with you to regain control over your own health and wellness.

Dr. Michelle Sthamann, ND

MICHELLELENA
wellness