New Patient Intake Form

Patient Information: Only complete this section if you are new to Integrative Interactive Health

Last name:_____First name:_____

Middle name:_____DOB:(DD/MM/YYYY)_____

Gender:

- ❑ Male
- ❑ Female
- ❑ MTF
- ❑ FTM
- ❑ Other: _____

Address:_____

City:_____Province:_____ Postal Code:_____

Email:_____

Phone numbers: (M)_____(W)_____(H)_____

Health card number:_____

Health Insurance provider:_____

Medical Information: If you are an existing patient of Dr. Tenisha Mitchell-Lambert, please skip to page 3

Thank you for taking the time to fill out this form. We know it is comprehensive, but the purpose is to get a thorough and accurate depiction of your health history to give your naturopathic doctor a more complete understanding of you. With this information we will be able to develop the most effective and specific treatment plan for your optimal health.

List any medical diagnoses: _____ _____

_____ _____

_____ _____

What medications do you take? (Please include names and dosages):

_____ _____

_____ _____

_____ _____

List any surgeries or hospitalizations you have had, including date occurred:

_____ _____

_____ _____

_____ _____

Allergies to medications:

- ❑ No
- ❑ Yes

If yes, list them:_____

Do you or have you ever smoked cigarettes or used other tobacco containing products?

- ❑ No
- ❑ Yes

If yes, indicate packs per day and numbers of years:

_____

Do you use any recreational drugs?

- ❑ No
- ❑ Yes

Do you drink alcohol?

- ❑ No
- ❑ Yes

If yes, how many drinks per week? (1 drink= 1.5oz hard liquor, 12 oz. beer, 5 ounces of wine)

- ❑ <1
- ❑ 2-7
- ❑ 8-14
- ❑ 15+

New Patient Intake Form

If yes, what types?

- ❑ Beer
- ❑ Wine
- ❑ Spirits
- ❑ Coolers
- ❑ Cocktails

Do you exercise?

- ❑ No
- ❑ Yes

If yes, how many days per week?

- ❑ 1-3
- ❑ 3-5
- ❑ 5+

How long is each session?

- ❑ <30 mins
- ❑ 30-60 mins
- ❑ >60 mins

How many times do you have sugar sweetened beverages per day?

- ❑ 0-1
- ❑ 2-3
- ❑ 4+

How much recreational screen time do you participate in per day? Circle one for each category:

TV	0-1 hour	2-3 hours	4+ hours
Tablet/Smart phone	0-1 hour	2-3 hours	4+ hours
Computer/Gaming system	0-1 hour	2-3 hours	4+ hours

New Patient Intake Form

Only complete this section if you are new to Dr. Sasha Coleman, N.D.

Most important concern you would like to address:

_____

Additional concerns?

_____

_____

_____

Family Medical History:

❏ Check here if adopted, and/or unsure of biological medical history

	Father	Mother	Siblings	Grandparents	Spouse	Children
Age if living:						
Age when died:						
Reason for death:						
Cancer type(s):						
High blood pressure						
Heart attack/stroke:						
Heart disease:						
Asthma/allergies:						
Mental illness:						
TB:						
Auto-immune disease:						
Diabetes:						
Osteoporosis:						

Past Medical History:

Please note when and/or why you had or were diagnosed with any of the following:

X-rays:		Last physical exam:		HIV:	
Ultrasounds:		Last blood work:		Hepatitis C Virus:	
MRI/CT scan:		Last dental visit:		TB test:	
Accidents:		Last eye exam:		Flu shot:	

Did you have the following Disease (D), Been Vaccinated (V), or Neither (N)? Circle answer:

Measles	D V N	Hemophilia	D V N	Rubella	D V N
Mumps	D V N	Chicken Pox	D V N	Tetanus	D V N
Hep B	D V N	Whooping Cough	D V N	Rubeola	D V N
HIB	D V N				

New Patient Intake Form

Any vaccination reactions? If so, explain_____

List all current supplements and medications (if not already noted above):

Supplement/Medication Name and Brand	Dose	Amount in each dose

Allergies to foods or medications (if not already noted above)?

- ❑ No
- ❑ Yes

If yes, what foods or medications?_____

Please fill out this information regarding your weight history:

Present weight:_____

Height:_____

Maximum weight, and

when:_____

Weight one year ago:_____

Minimum weight as an adult, and

when:_____

Any weight questions or concerns?

_____

Social History:

Regarding the next section: Please circle (Y) if you currently have the problem, (N) if you've never had the problem and (P) if you had the problem in the past, or fill in the blanks as appropriate.

What is your current occupation?		
Do you enjoy your job?	Y	N
Hours worked per week?		
Highest level of education?		
What are your hobbies?		

Relationship status:

- ❑ Single
- ❑ Widowed
- ❑ Common-law
- ❑ Other:_____
- ❑ Married
- ❑ In a relationship
- ❑ Separated
- ❑ Divorced

Do you live alone?

- ❑ No
- ❑ Yes

Do you have a support system?

- ❑ No
- ❑ Yes

New Patient Intake Form

Major stressors in the past or present (select all that apply):

- ❑ Finances
- ❑ Job
- ❑ Marriage/relationship
- ❑ Home life
- ❑ Children
- ❑ Loss
- ❑ Other:_____

Do you find your life?

- ❑ Satisfactory
- ❑ Unsatisfactory
- ❑ Boring
- ❑ Too demanding
- ❑ Other:_____

Do you have an active spiritual practice or religion?

- ❑ No
- ❑ Yes. If yes, please indicate type or practice

_____

History of sexual, mental/emotional, or physical abuse?

- ❑ No
- ❑ Yes. If yes, by whom and at what age?

_____

How active are these beliefs in your life, if any?

- ❑ Very active
- ❑ Somewhat active
- ❑ Not very active

How would you define your childhood memories?

- ❑ Mostly happy
- ❑ Normal
- ❑ Mostly painful
- ❑ Denies recollection

Have you received previous counseling?

- ❑ No
- ❑ Yes. If yes, please specify:
  - ❑ Psychiatrist
  - ❑ Psychologist
  - ❑ School counselor
  - ❑ Clergy

How committed are you to making valuable changes for your health?

- ❑ Slightly
- ❑ Moderate
- ❑ Very
- ❑ Don't know

What type(s) of exercise do you engage in, if any? (i.e. yoga- 30 mins, cardio- 30 mins)

_____

Sleep:

How many hours of sleep do you usually get per night?_____

Do you wake feeling refreshed?

- ❑ Always
- ❑ Usually
- ❑ Rarely
- ❑ Never

Do you have difficulty falling asleep?	Y	N
Do you have difficulty staying asleep?	Y	N
Do you snore?	Y	N
Do you grind your teeth?	Y	N
Do you have nightmares?	Y	N
Do you sleepwalk?	Y	N
Do you wake due to pain?	Y	N
Do you use a sleep aid?	Y	N
If yes to sleep aids, indicate what?		

New Patient Intake Form

Diet:

Do you follow a specific diet? (i.e. Paleo, Vegan, Keto, etc.)	Y	N	P
If yes, indicate type.			
How many meals do you eat a day?			
How much water do you drink each day (in ounces or cups)			
Do you drink caffeinated beverages	Y	N	P

Drugs, and Alcohol History:

Do you drink alcoholic beverages on a weekly basis?	Y	N	P
Do you or have you ever smoked cigarettes or used other tobacco containing products (i.e. e-cigarettes, hookah, cigars, chewing tobacco, etc.)	Y	N	P
Do you or have you ever used recreational drugs?	Y	N	P
If yes to drugs or alcohol use, does the use impair your activities of daily living?	Y	N	P
Have you ever been told you have an addiction or been treated for an addiction?	Y	N	P
If yes to addiction, when and for what?			

Toxin exposure:

Did you grow up near a refinery, polluted area, or in a home with leaded paint? If so, what sort of pollution?	Y	N
Are you particularly sensitive to perfumes, gasoline or other vapours?	Y	N
Do you use pesticides, herbicides or other chemicals around your home?	Y	N
Have you had any jobs where you were exposed to solvents, heavy metals, fumes or other toxic materials?	Y	N

Review of Systems:

General

Good energy:	Y	N	P
Rate your average energy level throughout the day using the scale 1-10 (1 is the lowest and 10 is the highest).			
Weight Change	Y	N	P
Appetite Change	Y	N	P
Fever/Chills	Y	N	P
Weakness	Y	N	P
Fatigue	Y	N	P
Night Sweats	Y	N	P

Ears

Ringing Ears	Y	N	P
Change In Hearing	Y	N	P
Ear Discharge	Y	N	P

Neck

Stiffness	Y	N	P
Full Movement	Y	N	P
Swollen Glands	Y	N	P
Tension	Y	N	P

Nose/Sinus

Nose Bleeds	Y	N	P
Polyps	Y	N	P
Problems Smelling	Y	N	P
Frequent Colds	Y	N	P
Postnasal Drip	Y	N	P
Nasal Congestion	Y	N	P
Nasal Discharge	Y	N	P
Sinusitis	Y	N	P

New Patient Intake Form

Mouth/Throat

Sore Throat	Y	N	P
Hoarseness	Y	N	P
Canker Sores	Y	N	P
Loss of Taste	Y	N	P
Cold Sores	Y	N	P
Gum Disease	Y	N	P
Cavities	Y	N	P
Problems Swallowing	Y	N	P
Dentures	Y	N	P

Eyes

Dry/Watery	Y	N	P
Double Vision	Y	N	P
Glaucoma	Y	N	P
Cataracts	Y	N	P
Strain	Y	N	P
Itchy	Y	N	P
Blurry Vision	Y	N	P
Red Eyes	Y	N	P
Styes	Y	N	P
Discharge	Y	N	P
Dark Under Eyelid	Y	N	P

Respiratory

Cough	Y	N	P
Shortness of Breath with Exertion	Y	N	P
Shortness of Breath Sitting	Y	N	P
Shortness of Breath Lying	Y	N	P
Wheezing	Y	N	P
TB	Y	N	P
Bronchitis	Y	N	P
Pneumonia	Y	N	P
Asthma	Y	N	P
Painful Breathing	Y	N	P
Emphysema	Y	N	P

Cardiovascular

High Blood Pressure	Y	N	P
Low Blood Pressure	Y	N	P
Arrhythmia	Y	N	P
Edema	Y	N	P
Rheumatic Fever	Y	N	P
Murmurs	Y	N	P
Palpitations	Y	N	P
Chest Pain	Y	N	P
Heart Attack	Y	N	P
Angina	Y	N	P
TIA/Stroke(s)	Y	N	P
Congestive Heart Failure	Y	N	P
Varicose Veins	Y	N	P

Urinary Tract

Incontinence	Y	N	P
Frequent Infections	Y	N	P
Urgency	Y	N	P
Pain with Urination	Y	N	P
Kidney Stones	Y	N	P
Discharge/Blood	Y	N	P
Waking to Urinate	Y	N	P

New Patient Intake Form

Gastrointestinal Tract

Indigestion	Y	N	P
Diarrhea	Y	N	P
Constipation	Y	N	P
Food Intolerance	Y	N	P
Abdominal Pain	Y	N	P
Heartburn	Y	N	P
Ulcers	Y	N	P
Hemorrhoids	Y	N	P
Gas/Bloating	Y	N	P
Nausea	Y	N	P
Vomiting	Y	N	P
Hernias	Y	N	P
Fatty meals bothering	Y	N	P
Rectal Bleeding/Burning/Itching	Y	N	P
Recent Bowel Movement Change	Y	N	P
Gallbladder disease	Y	N	P
Liver Disease	Y	N	P
How often do you have a bowel movement?			

Musculoskeletal

Weakness	Y	N	P
Stiffness	Y	N	P
Tremors	Y	N	P
Arthritis	Y	N	P
Leg Cramps	Y	N	P
Pain	Y	N	P
Muscle Aches	Y	N	P
Head Injury	Y	N	P

Skin/Integumentary

Rash	Y	N	P
Hives	Y	N	P
Psoriasis	Y	N	P
Eczema	Y	N	P
Dry Skin	Y	N	P
Color Change	Y	N	P
Itchy	Y	N	P
Warts/Moles	Y	N	P
Perspiration	Y	N	P
Skin Cancer	Y	N	P
Acne	Y	N	P
Hair/Nail Changes	Y	N	P
Rosacea	Y	N	P
Dry Hair	Y	N	P
Hair Loss	Y	N	P
Dandruff	Y	N	P
Oily Hair	Y	N	P

Neurological

Paralysis	Y	N	P
Sciatica	Y	N	P
Seizures	Y	N	P
Weakness	Y	N	P
Headaches	Y	N	P
Migraines	Y	N	P
Numbness/Tingling	Y	N	P
Tremors	Y	N	P
Carpal Tunnel	Y	N	P
Fainting/Blackouts	Y	N	P
Dizziness	Y	N	P
Lightheadedness	Y	N	P

New Patient Intake Form

Mental/Emotional

Anxiety	Y	N	P
Fear/Panic	Y	N	P
Eating Disorder	Y	N	P
Anger/Irritability	Y	N	P
Feeling down/Depressed	Y	N	P
Suicidal Thoughts	Y	N	P
High-Strung/Tense	Y	N	P
Psychiatric Hospitalization	Y	N	P

Endocrine

Diabetes	Y	N	P
Thyroid Disease	Y	N	P
Mood Swings	Y	N	P
Snacking often	Y	N	P
Hormone Therapy	Y	N	P
Increased Urination	Y	N	P
Increased Thirst	Y	N	P
Hot/Cold Intolerance	Y	N	P
Change in Glove/Shoe Size	Y	N	P
Difficulty Losing Weight	Y	N	P
Gain Weight Easily	Y	N	P

Hematological/Lymphatic

Anemia	Y	N	P
Easy Bruising/Bleeding	Y	N	P
Hemorrhoids	Y	N	P
Swollen Lymph Nodes	Y	N	P
Cold Hands/Feet	Y	N	P
Fragile/Sensitive Skin	Y	N	P
History of Blood Clots	Y	N	P
Deep Bone Pain	Y	N	P
Brittle Nails	Y	N	P

Female (Only females complete this section):

Menstrual cycle

Age Period Began		
First Day of Last Menses		
Are your cycles regular?	Y	N
Number of days in menses		
Bleeding between Cycles	Y	N
Clotting	Y	N

Check all the symptoms you experience before or during your menses?

- ❏ Diarrhea
- ❏ Bloating
- ❏ Food Cravings
- ❏ Mood Changes
- ❏ Headaches
- ❏ Heavy Bleeding
- ❏ Scanty Bleeding
- ❏ Menstrual Cramping
- ❏ Fatigue During Menses
- ❏ Backache During Menses
- ❏ Breast Tenderness/Swelling
- ❏ Nausea/Vomiting

New Patient Intake Form

Check all the pelvic symptoms you currently experience:

- ❑ Vaginal Itching
- ❑ Vaginal Odor
- ❑ Pelvic Pain
- ❑ Abnormal Discharge
- ❑ Rashes or Skin Changes
- ❑ Pain with Intercourse

Gynecology and PAP History

Date of Last PAP smear and results		
Have you ever had an irregular PAP smear?	Y	N

If yes to irregular PAP smear, list date and treatment received:

_____

Check all pelvic disease conditions that you have a history of:

- ❑ Ovarian cysts
- ❑ Fibroids
- ❑ Endometriosis
- ❑ Ectopic Pregnancy
- ❑ Ovarian/Uterine Disease
- ❑ Pelvic Inflammatory Disease
- ❑ Other:

_____

Breast Health

Date of last Mammogram and results:		
Do you do breast self-exams monthly?	Y	N

Check all the breast related symptoms you experience:

- ❑ Breast Pain
- ❑ Breast Discharge
- ❑ Breast Masses

Pregnancy History

Number of Pregnancies		
Number of Miscarriages		
Number of Abortions		
Any complications with pregnancy?	Y	N
Any difficulty with conceiving?	Y	N

Contraception, Libido, and Sexually Transmitted Infections (STIs)

Do you have sex with:

- ❑ Males
- ❑ Females
- ❑ Both Male and Female

Are you currently sexually active?	Y	N
Current number of sexual partners (if any)		
Do you have a history of STIs (sexually transmitted infections)?	Y	N

If yes to history of STI's, indicate type:

_____

Please indicate birth control or other hormones previously or currently used:

_____

Check all the symptoms you experience:

- ❑ Low libido
- ❑ Pain with intercourse
- ❑ Bleeding after intercourse

Menopause

Age at menopause (if applicable): _____

Check all the symptoms you experience:

- ❑ Hot flashes
- ❑ Night sweats
- ❑ Vaginal dryness
- ❑ Decreased libido
- ❑ Palpitations
- ❑ Mood changes
- ❑ Incontinence
- ❑ Joint pain
- ❑ Sleep disruption
- ❑ Brain fog or decreased memory

Date of last DEXA scan (bone density scan):

_____

New Patient Intake Form

Male (Only males complete this section):

Check all prostate/urinary symptoms you experience:

- ❑ BPH
- ❑ Nocturia
- ❑ Prostatitis
- ❑ Prostate cancer
- ❑ Incomplete urination
- ❑ Dribbling urine
- ❑ Difficulty initiating urination

Do you perform monthly testicular exams?	Y	N
Date of last PSA?		
Date of last prostate exam (digital rectal exam)?		

Check all the pelvic symptoms you currently experience:

- ❑ Testicular pain
- ❑ Testicular swelling
- ❑ Hernia
- ❑ Penile discharge
- ❑ Impotency
- ❑ Decreased libido
- ❑ Prostate disease
- ❑ Rashes or Skin changes

Additional Information:

Is there anything else you would like Dr. Coleman to know about you? Please write in the space below.