Dr. Laura Pipher, ND
Patient Intake Form (16 years+)

Date: _____

Personal information

Full Name: _____

Preferred Name (if different from above): _____

Date of Birth: _____ Age: _____ Sex:_____

Preferred pronoun: she/he/other _____

Home Address (Street, City, Province, Postal Code):

_____

Telephone (primary): _____ (mobile/ home/ work)

Telephone (secondary): _____ (mobile/ home/ work)

Which number is best to contact you? Primary / Secondary

Occupation: _____

Email Address (will be used for appointment reminders & follow ups as required):

_____

Emergency contact:

Name: _____ Phone: _____

Relationship to you: _____

How did you hear out about me?

_____

Your Health Care Team

Family Physician _____Phone:_____

Other Healthcare Providers (include profession):

Name: _____Phone: _____

Name: _____Phone: _____

Name: _____Phone: _____

Date of Last Physical Exam: _____ Was Blood work done? Y N

Clinic Expectations & Medical History

What are your main **HEALTH GOALS** for working with me?

1. _____
2. _____
3. _____

List your **HEALTH CONCERNS** in order of importance:

1.	2.
3.	4.
5.	6

Past Medical History:
Have you ever had any **serious conditions, illnesses, injuries or diseases** in the past? Please include approximate dates:

_____

_____

_____

_____

Please List ALL **Prescription Medications**

Name and Brand	**Dose and Frequency**

Please list ALL **Supplements, Vitamins, Herbs, & Non Prescription Medications (over the counter)**

Name and Brand	**Dose and Frequency**

Please List Any **Allergies** (food, drugs, environment etc) **& note their severity**:

Do you follow any dietary restrictions? Y / N

Explain: _____

Substance Use

Do you use any of the following: (please check all that apply)

- ☐ Tobacco – Cigarettes per day _____
- ☐ Alcohol- Type of alcohol _____, Drinks/ week: _____
- ☐ Marijuana- How many times/ week: _____

- Caffeine: Type of beverage: _____, Drinks/day _____
- Other substance (please specify type & use): _____

Family and Personal Health History

Please check the **YES** box beside any conditions affecting **Yourself OR A Close Relative** and indicate who (**F-father, M-mother, G-Grandparent, S- self**). Please circle whether the condition is **Past or Current**

Condition	**YES**		**Relation**	**Condition**	**YES**		**Relation**
Asthma		Past Current	M F G S	High blood pressure		Past Current	M F G S
Allergies		Past Current	M F G S	Heart disease		Past Current	M F G S
Anemia		Past Current	M F G S	Hepatitis		Past Current	M F G S
Arthritis		Past Current	M F G S	Headaches		Past Current	M F G S
Cancer		Past Current	M F G S	Kidney Disease		Past Current	M F G S
Diabetes		Past Current	M F G S	Stroke		Past Current	M F G S
Eczema		Past Current	M F G S	Tuberculosis		Past Current	M F G S
Epilepsy		Past Current	M F G S	Osteoporosis		Past Current	M F G S
Mental illness		Past Current	M F G S	Autoimmune disease		Past Current	M F G S
Addiction		Past Current	M F G S	Other:		Past Current	M F G S

How often are you physically active? _____ hours/ week

How many hours of your workday do you spend sitting? _____

What activities / hobbies do you enjoy? _____

Environment

Who do you live with? _____

How would you describe the **emotional climate** at home?

_____

Is there Anything else?

_____

_____

_____