Finlandia
PHARMACY & NATURAL HEALTH CENTRE

Retail Store & Pharmacy:
1111 West Broadway
Vancouver, B.C., V6H 1G1
(604) 733 - 5323

Health Centre:
G104 - 2480 Spruce
Vancouver, B.C. V6H 2P6
(604) 734 - 7760

Intake Form

Date: _____

Full Name: _____
Address: _____
City Province: _____
Postal Code: _____
Phone #: _____
Other #: _____
Email: _____
Birthday (M/D/Y): _____
Sex: _____
Height: _____
Weight: _____

Hair colour: _____
Eye colour: _____
Marital Status: _____
Occupation: _____
Family Doctor (FD): _____
FD Phone Number: _____
FD Fax: _____
FD Email: _____
FD Adress: _____
FD City / Province: _____

How did you hear about Finlandia's Naturopathic/Health Services:

__Newspaper/Magazine Ad
__Referral from a Friend/Family Member
__Staff at Finlandia
__Other: _____

How did you hear about Finlandia's Naturopathic/Health Services:

1. _____
2. _____
3. _____
4. _____

Past Medical History (including childhood diseases, surgeries, accidents, infectious diseases, degenerative conditions, allergies, hospitalization, abuse of drugs/alcohol/cigarettes):

_____
_____
_____

Please list all current medications (prescription, OTC, vitamins, herbs, homeopathics):

_____ _____
_____ _____
_____ _____

Please list past prescription medications:

_____ _____
_____ _____

Please list any allergies you may have:

_____ _____
_____ _____

Family medical history (including close relatives, siblings, children):

_____ _____ _____
_____ _____ _____

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Personal Heath Habits:

Height: _____
Weight: _____
Weight 1 yr ago: _____
Are you a smoker? Y N
How many years: _____
Packs/Day: _____
Do you drink alcohol? Y N
Type: _____
Frequency: _____

Do you use recreational drugs? Y N
Type: _____
Fequency: _____
Do you drink coffee? Y N
Cups/day: _____
Tea? Y N
Cups/day: _____

Do you exercise regularly? Y N
Type: _____
Frequency: _____
Hours of sleep/night: _____
Do you stay asleep through the night? Y N
Wake up rested? Y N

Personal Heath Habits:

Breakfast: _____
Lunch: _____
Dinner: _____
Beverages: _____

Environment:

Occupation: _____
Hobbies: _____
Exposure to animals: _____
Exposure to toxins: _____

Personal Heath Habits:

Are you currently pregnant? Y N
# of months: _____
# of pregnancies: _____

# of miscarriages: _____
# of abortions: _____
Difficulty conceiving? Y N

Date and result of last Pap smear: _____
_____
_____

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?

_____
_____
_____

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Review of Systems (Please check if you have experienced any of these in the last 12 months):

Skin and Hair
___Rashes
___Itching
___Dandruff
___Change in texture
___Poor healing sores
___Eczema
___Loss of hair
___Hives
___Pimples
___Recent moles

Head
___Light headedness
___Fainting
___Loss of memory
___Difficulty concentrating
___Headaches/Migraines
___Sinus congestion

Eyes
___Eye pain
___Sensitive to light
___Loss of vision
___Blurred vision
___Difficulty seeing at night
___Itchy, inflamed or Infected
___Glaucoma/Cataracts

Ears
___Loss of hearing
___Loss of balance
___Dizziness
___Ear pain
___Ringing in ears
___Ear infections

Mouth
___Sores on lip/mouth
___Loss of taste
___Painful gums or tongue

Throat
___Sore throat/hoarseness
___Difficulty swallowing

Nose
___Loss of smell
___Nose pain
___Nosebleeds

Lungs
___Shortness of breath
___Difficulty breathing
___Chronic cough
___Chronic phlegm/mucus
___chronic infections

Immunity
___frequent colds
___Use antibiotics

Cardiovascular
___High blood pressure
___Low blood pressure
___Irreg. heart beat
___Phlebitis
___Palpitations
___Swelling of hands/feet
___Varicose veins
___Chest pain
___Cold hands/feet
___Blood clots
___Difficulty breathing

Respiratory
___Cough
___Coughing blood
___Difficulty breathing when lying down
___Production of phlegm
___Bronchitis
___Pneumonia
___Asthma
___Pain on breathing

Gastro-Intestinal
___Nausea
___Constipation
___Abdominal pain
___Blood in stools
___Hemorrhoids
___Food cravings
___Vomiting
___Black stools
___Indigestion
___Mucous in stools
___Gas
___Poor appetite
___Diarrhea
___Bad breath
___Heartburn
___Rectal pain
___Bloating
___Difficulty swallowing
___# of bowel mvts/Day

Urinary
___Pain on urination
___Urgency of urination
___Impotency
___Frequent urination
___Kidney stones
___Inability to hold urine
___Blood in urine
___Irregular flow

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Informed Consent

Statement of Acknowledgement

As a patient of this Health Centre I have read the information and understand that the form of medical care is based on alternative and other supportative principles and practices. As Finlandia is an integrated health centre, I recognize that all the practitioners that are working with me will have access to my file. I also recognize that even the gentlest therapies potentially have their complications in certain physiological conditions or in very young children or those on multiple medications and hence the information provided is complete and inclusive of all health concerns including risk of pregnancy; and all medications, including over the counter drugs and supplements. The slight health risks of some treatments include, but not limited to; aggravation of pre-existing symptoms, allergic reaction to supplements or herbs; pain, fainting, bruising or injury from venipuncture or acupuncture; muscle strains and sprains.

I also confirm that I have the ability to accept or reject this care of my own free will and choice and that I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating. I accept full responsibility for any fees incurred during care and treatment.

_____ _____

Signature Date