



*Braidwood Naturopathic Clinic*

Drs. Heather Marinaccio, ND and Erika Kneeland, ND

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***New Patient Intake Form***

*Drs. Erika Kneeland, ND and Heather Marinaccio, ND*

Today's date: \_\_\_\_\_

Your name: \_\_\_\_\_

Your date of birth: \_\_\_\_\_ Phone: \_\_\_\_\_

Email: \_\_\_\_\_

Are you familiar with naturopathic medicine? \_\_\_\_\_

How did you hear about our Clinic? \_\_\_\_\_

Main reason(s) for seeking Naturopathic medical care. Please indicate order of importance and when symptoms first appeared.

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

Medical Doctor's name: \_\_\_\_\_

Do you consult with other health care professionals? If so, please list: \_\_\_\_\_

\_\_\_\_\_

Please list medication/drugs you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Please list all supplements you are currently taking: \_\_\_\_\_

\_\_\_\_\_

Do you wear a medic alert bracelet? **Y** **N** If so, for which condition? \_\_\_\_\_

Do you have a pacemaker? **Y** **N**

Do you have any medication/drug related allergies? **Y** **N** \_\_\_\_\_

Do you have any food/environmental allergies or sensitivities: **Y** **N**

If so, please list: \_\_\_\_\_

**For Women:** Date of last PAP test? \_\_\_\_\_

*(This screening is offered by Dr. Kneeland and Dr. Marinaccio)*

Age of first menstrual period? \_\_\_\_\_

If over 40, date of last mammogram? \_\_\_\_\_

**Please circle any of the following conditions you have had:**

Alcoholism/Allergies/Anemia/Arthritis/Asthma/Cancer/Chicken pox/Cold sores/Depression/  
Diabetes/Ear infections/Eczema/Emphysema/Epilepsy/Frequent colds/Gall stones/Gonorrhea/  
Gout/Hay fever/Heart disease/Hepatitis/Herpes/Influenza/Kidneydisease/Leukemia/Malaria/Measles/  
Miscarriage/Mononucleosis/Mumps/Parasites/Pelvic inflammatory disease/Peritonitis/Pleurisy/  
Pneumonia/Prostatitis/Recurrent infections/Rheumatic fever/Rubella/Scarlet fever/Skin disease/  
Strep throat/Sinusitis/Sunstroke/Thyroid disease/Tonsillitis/Tuberculosis/Warts/Whooping cough

Are there any conditions after which you have never been totally well since, or which have been more serious than usual? \_\_\_\_\_

**Please list any operations, hospitalizations, childbirths, major accidents or traumas you have had:**

Date: \_\_\_\_\_ Date: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_  
Date: \_\_\_\_\_ Date: \_\_\_\_\_

**Please indicate below which of the following conditions have affected your relatives:**

Indicate: F=Father, M=Mother, S1=Sibling, S2=Sibling etc, PGM=Paternal Grandmother, MGM=Maternal Grandmother, PGF= Paternal Grandfather, MGF= Maternal Grandfather, PA=Paternal Aunt, MA=Maternal Aunt, PU=Paternal Uncle, MU=Maternal Uncle

Alcoholism: Heart disease:  
Allergies: High blood pressure:  
Arthritis: Mental illness:  
Asthma: Osteoporosis:  
Autoimmune disease: Pneumonia:  
Cancer (type): Skin disease:  
Depression: Thyroid disease:  
Diabetes: Tuberculosis:  
Hay fever: Gout:

**Do you (please circle):**

Smoke/Drink alcohol regularly/Drink coffee/Tea/Pop/Use recreational drugs/Use antacids/  
Steroids or Laxatives

**Have you lost any weight recently? How many pounds?** \_\_\_\_\_

**What exercise do you do and how much?** \_\_\_\_\_

**What are your short-term health goals?** \_\_\_\_\_

**What are your long-term health goals?** \_\_\_\_\_