Dear New Patient:

Thank you for choosing Port Moody Health as your integrative health care provider. We are conveniently located in the scenic community of Port Moody. Free parking is available on the premises. Please note that our office is scent-free to respect those clients with allergies or sensitivities. The office accepts payment by debit, Visa, MasterCard, cash, and direct billing. Most extended health care providers cover Naturopathic visits. Please check with your provider to determine the amount that is covered under your policy. We do offer directing billing for Chamber of Commerce, Cowan, Desjardins, Great-West Life, Industrial Alliance, Johnson Inc., Manulife, Maximum Benefit, Standard Life and Sun Life.

Enclosed are a contact form and a detailed intake questionnaire. Please fill out the questionnaire and bring it with you to your appointment.

What to expect from your first visit:

- ✓ Please arrive **15 minutes prior** to your scheduled appointment in order to provide a urine sample prior to the start of your visit.
- ✓ The first visit with your naturopathic physician is 45 to 60 minutes in length and involves a review of the detailed intake questionnaire, full health history, macroscopic urine analysis and, if necessary, may include a partial physical exam.
- ✓ Some laboratory tests, such as specific blood, urine or saliva analysis may also be recommended at this time but are not included in the cost of the visit.
- ✓ Subsequent visits vary from 15 minutes to 75 minutes in length.
- ✓ Treatments and therapies are an additional cost.

What to bring for your first visit:

- ✓ Your completed new patient forms. You may fax these to us in advance.
- ✓ Copies of any blood work or laboratory reports that are recent as of the last six months (or longer if appropriate) and any other pertinent documents.
- ✓ If possible, please bring medications or supplements that you are currently taking.

In the event that you must reschedule your appointment we do require 2 business days' notice or the full charge of the visit fee will be applied. Changes can only be made in person or via telephone, not e-mail.
Please note, all product purchases are final. We do not issue returns or exchanges.
Thank you for your cooperation.

Kindly give us a call at 604-949-0077 if you have any questions.
We look forward to meeting you.

Yours in Health,
The Port Moody Health Team

Modern Healthcare for the Whole Family

202-101 Klahanie Drive, Port Moody, BC | www.portmoodyhealth.com | T: 604 949 0077 F: 604 949 0017

Dr. Sharon Gurm, ND, Integrated Health LTD.

CONTACT INFORMATION

Full Name: ____

Name of Parent or Guardian if under age of 18: ______________________________________

Date of Birth: ________________ Sex: ☐Male ☐Female Ethnicity:________________

Occupation: _______________________ Personal Health No. _______________________

Full Address:

____

____

Postal Code: ___________________ Email: __________________________________

Would you like to sign-up for our e-Newsletter? ☐YES ☐NO Initial: ________

Telephone: (home) ______________ (work) ______________ (mobile) ______________

Preferred form of contact for reminder/follow-up calls:

☐Home Number ☐Work Number ☐Mobile Number

Emergency Contact Name: ____

Relation: ___________________________Telephone: ____________________________

Name of Medical Doctor: ____

Address: ____

Telephone: ______________________ Date of last visit: __________________________

How did you hear of us?

____

Were you referred by someone? If yes, whom? ____________________________________

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Adult Intake Form

Please fill out this form to the best of your ability. It will help to assess your present health and will assist in facilitating the healing process.

Preferred First Name: ______________________ Last Name: ________________________

Age: __________ Height: __________ Current Weight: __________

List all prescribed medications currently taken and include: **dose, frequency, and duration** (how long you have been taking them).

1.

2.

3.

List any medication allergies (for example penicillin):

____

List all over-the-counter medications that you take (for example: Aspirin, Tums, Tylenol) and include **dose and frequency**:

____

Please list any significant illness or health concerns pertaining to your immediate family members:

____

____

List any surgeries and/or hospitalizations along with the dates (including dental surgeries, tooth extractions, root canals, etc.):

____

____

List any severe accidents or injuries in the past along with the dates:

____

How many courses of antibiotics have you been on in the last 5 years? (Indicate the reason for prescription):

____

What are your health concerns, in order of importance?

1.

2.

3.

List all vitamins, minerals, herbal medicines, Asian medicines, or homeopathics you are currently taking and include dosage and frequency:

____

____

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

---

What type of vaccinations have you received? ______________________________________

Have you ever experienced an adverse reaction to the above vaccinations? ____________________

Do you drink alcohol? If yes, what type, and how often?

____

Do you smoke? If yes, since when, and how many a day? If you smoked in the past, please indicate the **frequency and duration**.

____

Do you currently or have you in the past used any recreational drugs? If yes, indicate type and frequency and duration of usage:

____

Do you presently have mercury (silver) fillings in your mouth? How many? ________

Have you had any mercury fillings replaced? How many? _____

Did you receive chelation at the time of removal? ☐YES ☐NO

Please list any known past or present toxic exposures (occupational, residential, medical, environmental, etc.):

____

____

Please list past regions of long-term residence (along with dates, duration) if different than your current residence: ____

Describe your general state of health as a child: ____________________________________

Describe your general state of health as a teenager: __________________________________

Do you have any dietary restrictions, or food sensitivities or allergies? If so, please describe: ________

____

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Please provide details about your average daily diet:

Breakfast:

Lunch:

Dinner:

Snacks:

Beverages:

Water Intake: litres per day __________ Source: ☐Tap ☐Bottle ☐Filtered ☐Other ________________________

Do you exercise? If so, indicate the type, frequency and duration that you have been exercising

____

List your hobbies or interests: ____

What level of personal stress are you experiencing at the present moment?

☐Minimal ☐Average ☐Considerable ☐Unbearable

What are the main stressors in your life? ____

Do you have difficulty falling and/or staying asleep? If yes, please explain**:** ___________________________

Do you wake up feeling refreshed? ☐Yes ☐No

How would you rate your overall energy out of 10 (10 being the optimal level you would like to achieve)?

________/10

If applicable, at what time(s) of the day do you experience the lowest energy?

____

Please circle 'Y' if you are currently experiencing the condition. Please circle 'P' if you had the condition in the past. **Write comments to the right as necessary to provide details/specifics.**

SKIN

Itching	Y	P	
Dryness	Y	P	
Hives (allergy)	Y	P	
Eczema	Y	P	
Psoriasis	Y	P	
Boils	Y	P	
Acne	Y	P	

Rosacea	Y	P	
Skin cancer	Y	P	Type:
Change in moles	Y	P	
Weak nails (of hands or feet)	Y	P	
Nail fungus (of hands or feet)	Y	P	

HEAD

Headaches	Y	P	
Migraines	Y	P	
Head injury/trauma	Y	P	
Dizziness	Y	P	
Loss of hair	Y	P	

EYES

Date of last Optometrist Visit:			
Glasses/contact lenses	Y	P	
Eye pain	Y	P	
Tearing	Y	P	
Dryness	Y	P	
Floaters	Y	P	
Double vision	Y	P	
Blurring	Y	P	
Cataracts	Y	P	
Glaucoma	Y	P	
Bothered by sun	Y	P	
Blind spot	Y	P	
Night/colour blindness	Y	P	

EARS

Impaired hearing	Y	P	
Earache	Y	P	
Discharge	Y	P	
Infections	Y	P	
Tinnitis (ringing in the ears)	Y	P	

NOSE

Frequent colds	Y	P	
Nose bleeds	Y	P	
Stuffiness/Congestion	Y	P	
Hay fever	Y	P	
Sinus infections	Y	P	

MOUTH AND THROAT

Date of Last Dental Visit:			
Frequent sore throats	Y	P	

Sore tongue/mouth	Y	P	
Difficulty swallowing	Y	P	
Gum Recession	Y	P	
Gum Disease/Gingivitis	Y	P	
Hoarse voice	Y	P	
Loss of taste	Y	P	
Dry mouth	Y	P	
TMJ Syndrome (jaw clicking)	Y	P	
Halitosis (bad breath)	Y	P	

NECK

Pain or stiffness	Y	P	
Enlarged thyroid	Y	P	
Enlarged lymph nodes	Y	P	

RESPIRATORY

Cough	Y	P	
Sputum	Y	P	
Wheezing	Y	P	
Asthma	Y	P	
Bronchitis	Y	P	
Difficulty breathing	Y	P	
Pain on breathing	Y	P	
Shortness of breath (when?)	Y	P	
Pressure or tightness in the chest	Y	P	

CARDIOVASCULAR

Heart disease	Y	P	
High blood pressure	Y	P	
High cholesterol	Y	P	
Chest pain	Y	P	
Angina	Y	P	
Swelling in ankles/feet	Y	P	
Palpitations, fluttering	Y	P	

GASTRO-INTESTINAL

Heartburn/reflux	Y	P	
Change in thirst/appetite	Y	P	
Nausea/vomiting	Y	P	
Bowel movements - **how often?**			
Blood in stool	Y	P	
Belching/passing gas/bloating	Y	P	
Liver/gallbladder disease/stones	Y	P	
Ulcer	Y	P	
Indigestion	Y	P	
Diarrhea	Y	P	
Constipation	Y	P	

Hemorrhoids	Y	P	
Intestinal worms and/or parasites	Y	P	

URINARY

Pain on urination	Y	P	
Increased frequency	Y	P	
Inability to hold urine	Y	P	
Frequent urinary infections	Y	P	
Kidney stones	Y	P	
Blood in urine	Y	P	

IF MALE, PLEASE FILL OUT THE FOLLOWING:

Testicular masses/pain	Y	P	
Are you or have you been sexually active?	Yes	No	
Sexual difficulties	Y	P	
Venereal disease	Y	P	
Have you ever had a digital rectal (prostate) exam and/or PSA test?	Y	P	
If so, please indicate your last evaluation and any pertinent details:			

IF FEMALE, PLEASE FILL OUT THE FOLLOWING:

Age menses began					
Average number of days of menses					
Average length of cycle					
Bleeding between periods	Y	P			
Irregular cycles	Y	P			
Pain during intercourse	Y	P			
Painful menses	Y	P			
PMS	Y	P			
Excessive flow	Y	P			
Breast tenderness	Y	P			
Breast lumps/cysts/discharge	Y	P			
Last menstrual period (date)					
Vaginal discharge	Y	P			
Vaginal itching	Y	P			
Are you or have you been sexually active?	Yes	No			
Difficulty conceiving	Yes	No			
Birth control?			Currently	Never	Past
What type? When?					
Number of pregnancies					
Number of live births					

Number of miscarriages			
Number of abortions			
Sexual difficulties	Y	P	
Venereal disease	Y	P	
Last PAP (date)			
History of abnormal PAP?	Yes	No	If yes, when?
Have you ever had a mammogram, breast ultrasound, pelvic or transvaginal ultrasound?	Yes	No	
	Yes	No	
Do you receive regular mammograms?	Yes	No	List any
Please indicate when, frequency of imaging (i.e. yearly) and any pertinent details			

MUSCULOSKELETAL

Joint pain and/or stiffness	Y	P	
Arthritis	Y	P	
Broken bones	Y	P	
Muscle spasms or cramps	Y	P	
Backache	Y	P	
Foot pain	Y	P	
Injury (tendon/ligament/joint)	Y	P	
Significant joint swelling	Y	P	

PERIPHERAL VASCULAR

Deep leg pain	Y	P	
Cold hands/feet	Y	P	
Varicose veins and/or spider veins	Y	P	
Extremity numbness or tingling	Y	P	

NEUROLOGICAL

Fainting	Y	P			
Seizures/convulsions	Y	P			
Paralysis	Y	P			
Loss of memory	Y	P			
Involuntary movement	Y	P			
Loss of balance	Y	P			
Speech problems	Y	P			

ENDOCRINE (circle all that apply where necessary)

Heat and/or cold intolerance	Y	P	
Thyroid abnormalities	Y	P	
Excessive sweating or lack of	Y	P	
Excessive thirst/hunger/urination	Y	P	
Diabetes Type (I) or (II)	Y	P	

Hypoglycemia/Hyperglycemia	Y	P	
Hormone therapy (past or present)	Y	P	

BLOOD/LYMPHATIC

Anemia	Y	P	If yes, what type?
Easy bleeding/bruising	Y	P	
Lymph node swelling	Y	P	

EMOTIONAL

Depression	Y	P	
Mood swings	Y	P	
Anxiety or nervousness or tension	Y	P	
Diagnosed mental illness	Y	P	
Alcohol/Drug abuse	Y	P	
Emotional Eating	Y	P	
Insomnia	Y	P	

Thank you for answering all the questions. Complete answers to all of the questions are to your benefit for the most effective naturopathic assessment, diagnosis and treatment.

This is a **confidential** record of your medical history and will be kept in this office.
Information contained here will not be released to any person except when you have authorized us to do so.