



Dr. Simone Baum
 Naturopathic Physician
 Family Medicine & Women's Health

Tel: 604-727-7166 Fax: 604-677-6035 Email: simone@drsimonebaum.com

New Patient Intake Form

Please complete the following form as thoroughly as possible.

All information is confidential.

Name _____ Date _____

Age _____ Date of Birth _____

Street _____

City _____ Province _____ Postal Code _____

Phone _____ Work Phone _____

Email Address _____

Occupation _____ Employer _____

Gender: M or F Relationship Status _____

Emergency Contact Name _____

Emergency Contact Phone _____

Name of Other Healthcare Providers: _____

Reasons for Seeing Other Healthcare Providers _____

General Practitioner's (MD) Name/Address/Phone _____

Last visit to MD _____

Reason for visit today _____

Please list your most important health concerns in order of importance:

1. _____ 6. _____

2. _____ 7. _____

3. _____ 8. _____

4. _____ 9. _____

5. _____ 10. _____

How did you hear about Dr Simone Baum? _____

Referring Doctor _____

Cancellation Policy:

I understand that I am responsible for the full payment of treatment if I do not give 24 hours notice of change or cancellation.

Consent:

I consent to receive treatment by Dr Simone Baum. I understand that my consent is voluntary and can be revoked by me at any time.

Signature _____ Date _____

(Parent or Guardian if a minor)

Health History

Please list allergies/sensitivities (Food/Chemical/Environmental/Drug) _____

Please list Hospitalizations/Surgeries/Imaging have you had and in what year?

Please list medications you are currently taking (include dosage):

Please list supplements you are currently taking:

Family History

Please list the ages and health concerns of living relatives.

If deceased, please indicate what age they died and the cause if known:

Mother _____

Father _____

Siblings _____

Grandparents _____

Have any of your blood relatives experienced:

Allergies		Hayfever/Hives	
Anemia		Hemophilia	
Arthritis		High Blood Pressure	
Asthma		High Cholesterol	

Cancer		Kidney Disease	
Diabetes		Migraines	
Depression		Thyroid Imbalances	
Eczema		Heart Disease/Stroke	
Epilepsy		Other	

Please list any other relevant family history _____

Please check if you have experienced the below in the past year or have significantly experienced any of the below:

Childhood

Measles		Mumps	
Rubella		Diphtheria	
Rheumatic Fever		Chicken Pox	
Vaccinated/Immunized			

Others _____

Skin

Acne		Psoriasis	
Eczema		Hives	
Mole Changes		Sunburn	
Itching		Rash	
Redness		Lumps	
Sores		Night Sweats	
Dryness		Hair loss	
Other			

Eyes

Impaired Vision		Excessive tearing	
Eye Pain		Excessive dryness	
Double vision		Glaucoma	
Blurred vision		Macular degeneration	
Cataracts		Other	

Ears

Impaired hearing		ringing	
Earache		Dizziness	
Other			

Nose and Sinuses

Frequent colds		Nosebleeds	
Stiffness		Hay fever	

Sinus Pain		Sinus congestion	
Other			

Mouth and Throat

Sore Throat		Trouble swallowing	
Gum Problems		Sore tongue	
Hoarseness		Mouth/tongue Cancer	
Tooth pain		Canker sores	
Cold sores		Cracked lips	
Other			

Neck

Enlarged Neck		Pain/stiffness	
Lumps		Swollen glands	
Other			

Neurological

Fainting		Seizures	
Dizziness		Muscle weakness	
Numbness/tingling		Memory loss	
Other			

Respiratory

Shortness of Breath		Wheezing	
Chest congestion		Cough	
Sputum		Asthma	
Pleurisy		Pain with breathing	
Bronchitis		Pneumonia	
Lung Cancer		Emphysema	
Exposed to chemicals		Other	

Cardiovascular

High blood pressure		High Cholesterol	
Angina/chest pain		Murmurs	
Heart Disease		Heart attack	
Pain on walking		Swelling in ankles	
Heart palpitations		Pacemaker	
Other			

Gastrointestinal

Difficulty swallowing		Heartburn/Gastritis	
Stomach pain		Change in appetite	

Nausea		Vomiting	
Gas pain		Ulcers	
Hemorrhoids		Constipation	
Diarrhea		Jaundice	
Liver disease		Gallbladder disease	
Colitis		Bloating	
Colon polyps		Belching/passing gas	
Other			

Bowel movements How often? _____/day

Do you have blood/mucous/undigested food in your stool? _____

Urinary

Pain on urination		Increased frequency	
Urgency		Inability to hold urine	
Frequent infections		Kidney stones	
Other			

Endocrine

Thyroid problems		Hot flashes	
Excessive thirst		Sugar cravings	
Weight loss		Weight gain	
Hair loss		Cold hands and feet	
Chronic fatigue		Diabetes	
Excessive sweating		Other	

Blood

Anemia		Easy bleeding	
Bleeding disorder		Other	

Immune

Chronic fatigue		Chronic infections	
Chronically swollen glands		Slow wound healing	
Reactions to vaccines		Cancer	
Reactions to immunizations		Other	

Muscular Skeletal

Joint pain/stiffness		Weakness	
Broken bones		Sciatica	
Muscle spasms		Arthritis	
Other			

Female Reproductive

Irregular cycles		Currently pregnant	
Breast tenderness		# of live births	
Cramps with menses		# of abortions	
Skipped cycles		Currently sexually active	
Age at first period		Contraception type	
PMS		History of STDs	
Nipple discharge		# of pregnancies	
Heavy bleeding		# of miscarriages	
Emotional changes		Sexual difficulties	
Abnormal PAP		Difficulty conceiving	
Hysterectomy		Self breast exams	
Other			

Date of last PAP smear _____

Length of period (number of days) _____

Do you bleed between periods? _____

Frequency of cycle (how many days apart are your cycles?) _____

Have you reached menopause? _____ If yes, at what age? _____

Menopausal symptoms _____

Have you had a mammogram? _____ If yes, when? _____

Male Reproductive

Hernias		Testicular masses/pain	
Sexually active		Sexual difficulties	
History of STDs		Discharge or sores	
Impotence		Penile pain	
Scrotal pain		Erectile difficulty	
Other			

Peripheral Vascular

Deep leg pain		Cold hands/feet	
Swelling feet/ankles		Varicose veins	
Thrombophlebitis		Other	

Mental/Emotional

Depression		Mood swings	
Anxiety		Anger/frustration	
Insomnia		Phobias	
Suicide attempt		Other	

Have you ever been treated for mental/emotional problems? _____

Habits

What are your main interests and habits?

Do you eat 3 meals a day? _____

Are you avoiding any foods or food groups? _____

Please indicate your typical diet:

Breakfast _____

Snack _____

Lunch _____

Snack _____

Dinner _____

Snack _____

Do you consume coffee/tea/sodas? ___ How many per day? _____ Per week? _____

Do you consume alcohol? ___ How much per day? ___ Per week? ___ At one time? _____

Do you or have you ever smoked cigarettes? ___ For how long? ___ How many per day? _____

Do you use recreational drugs? _____ What kind? _____ For how long? _____

How many hours a night do you sleep? _____

What time do you go to sleep and what time do you wake up? _____

Do you stay asleep during the night? _____ Do you wake up feeling refreshed? _____

How many hours a week do you work? _____ Do you enjoy your work? _____

What form of exercise do you do? _____ How often do you exercise/week? _____

Please indicate your expectations from your visit and your wish for your outcome of your visits with Dr Simone Baum _____

Thank you for your time in providing this information.

Dr Simone Baum looks forward in working with you.