Semiahmoo Wellness Centre
305 1656 Martin Drive
Surrey, BC. V4A6E7

Dr. Justyna Sommer, N.D.

Patient Intake Form

PATIENT INFORMATION Date

Thank you for choosing us to be a part of your healthcare team!

Full Name_____

Care Card Number (PHN)_____

Birthday (mm/dd/yyyy)_____ Age_____ Gender_____

Marital Status ☐ Married ☐ Common Law ☐ Divorced ☐ Widowed ☐ Single

Home Address_____

City_____ Postal Code_____

Primary Telephone (_____)-_____-_____ Cellphone (_____)-_____-_____

Email_____(We will not share, rent or sell your email address)

I would like to be reminded of my upcoming appointments via... ☐ Email ☐ Text ☐ Phone Call

IF text, who is your cell provider?_____

I consent to Semiahmoo Wellness Centre health staff and practitioners corresponding with me via the email address I have provided ☐ Yes ☐ No

I would like to receive Semiahmoo Wellness Centre's free email newsletter featuring clinic news and health & wellness information ☐ Yes ☐ No (You may unsubscribe at any time)

Occupation_____Work Telephone(_____)-_____-_____

May doctor/practitioner and/or staff contact you at work? ☐ Yes ☐ No

Name of Emergency Contact_____

Relation to you_____Telephone(_____)-_____-_____

Where did you hear about Semiahmoo Wellness Centre?_____

Do you have Extended Health Care? ☐ Yes ☐ No Provider_____

Policy No_____ Member ID_____

Are you the Primary Coverage Holder? ☐ Yes ☐ No

Primary Holder's Name (if different)_____

Primary Holder's Birthdate (if different) [mm/dd/yyyy] _____

HEALTH ISSUES

Main Concern_____

When did this condition begin?_____

Do other family members have the same condition?_____

Doctors seen for this condition_____

Other Concern (s)_____

Is your condition part of an ICBC or WCB claim?_____

Did you receive typical childhood vaccinations? ☐ Yes ☐ No

Allergies_____

Major Surgeries/Operations_____

Major Accidents/Falls_____

Serious Infections/Diseases (Cancer, Pneumonia, T.B.,etc)_____

Dental Intervention (root canals, fillings, etc)_____

Psychological Traumas_____

Hospitalization (other than above)_____

Previous Naturopathic Care (Doctors name and approximate date of last visit)

_____

MEDICATIONS [Please list any medications/supplements you are taking]

Medications _____ _____

(prescription, _____ _____

over the counter) _____ _____

Supplements _____ _____

(multivitamins, _____ _____

gingko, etc.) _____ _____

LIFESTYLE

Overall stress level ☐ none ☐ low ☐ medium ☐ high

How often do you exercise?_____

Type of exercise_____

Do you currently smoke? ☐ Yes ☐ No

If yes, how often?_____

FOR WOMEN

Are you pregnant? ☐ Yes ☐ No ☐ Maybe If yes, Due Date_____

Do you have children? ☐ Yes ☐ No

Menstrual Cycle ☐ Regular ☐ Irregular ☐ Painful

Date of last Cycle_____

Are you planning on starting a family? ☐ Yes ☐ No If yes, when?_____

Below is a list of diseases which may seem unrelated to the purpose of your appointment. However, these questions must be answered carefully as these problems can affect your overall course of treatment.

CHECK ANY OF THE FOLLOWING DISEASES YOU HAVE HAD

___Pneumonia
___Rheumatic Fever
___Polio
___Tuberculosis
___Whooping Cough
___Anemia
___Measles
___Mumps
___Small Pox
___Chicken Pox
___Diabetes
___Cancer
___Heart Disease
___Thyroid
___Influenza
___Pleurisy
___Arthritis
___Epilepsy
___Mental Disorder
___Lumbago
___Eczema

HABITS:	**Heavy**	**Medium**	**Light**	**None**
Alcohol				
Coffee				
Tea				
Tobacco				
Drugs				
Exercise				
Sleep				
Appetite				
White Sugar				

CHECK ANY OF THE FOLLOWING YOU HAVE HAD DURING THE PAST 6 MONTHS:

MUSCULO-SKELATAL CODE
___Low back pain
___Pain between shoulders
___Neck Pain
___Arm Pain
___Joint Pain/Stiffness
___Walking Problems
___Difficulty Chewing/Clicking Jaw
___General Stiffness

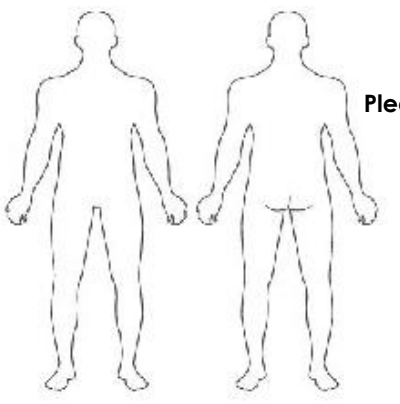
NERVOUS SYSTEM
___Nervous
___Numbness
___Paralysis
___Dizziness
___Forgetfulness
___Confusion/Depression
___Fainting
___Convulsions
___Cold/Tingling Extremities
___Stress

GENERAL CODE
___Fatigue
___Allergies
___Loss of Sleep
___Fever
___Headaches

GENITO-URINARY CODE
___Bladder Trouble
___Painful/Excessive Urination
___Discoloured Urine

C-V-R CODE
___Chest Pain
___Short Breath
___Blood Pressure Problems
___Irregular Heartbeat
___Heart Problems
___Lung Problems/Congestion
___Varicose Veins
___Ankle Swelling
___Stroke

EENT CODE
___Vision Problems
___Dental Problems
___Sore Throat
___Ear Aches
___Hearing Difficulty
___Stuffed Nose



GASTRO-INTESTINAL CODE
___Poor/Excessive Appetite
___Excessive Thirst
___Frequent Nausea
___Vomiting
___Diarrhoea
___Constipation
___Haemorrhoids
___Liver Problems
___Gall Bladder Problems
___Weight Trouble
___Abdominal Cramps
___Gas/Bloating after meals
___Heartburn
___Black/Bloody Stool
___Colitis

MALE/FEMALE CODE
___Menstrual Irregularity
___Menstrual Cramping
___Vaginal Pain/Infections
___Breast Pain/Lumps
___Prostate/Sexual Dysfunction
___Genital Herpes

Please outline on the diagram the area of your discomfort

Why Naturopathic Medicine? People go to naturopathic physicians for a variety of reasons. Some go for symptomatic relief of pain or discomfort (Relief Care). Others are interested in having the cause of the problem as well as their symptoms corrected and relieved (Corrective Care). Still others want whatever is malfunctioning in their bodies brought to the highest state of health possible (Preventative Care). These are the three phases of care. Your doctor will weigh your need and desires when recommending your schedule of care. However, his/her prepared recommendation is an incorporation of all three phrases.

Please check the type of care desired so that we may be guided by your wishes whenever possible.

_____ Relief Care _____ Corrective Care _____ Preventive Care _____ Check here if unsure

_____ (Date)

_____ (Patient Name)

_____ (Signature)

If this is an accident related injury, please fill out the accident form. Thank you

The purpose of our office is to support each individual in achieving their optimum health and educate them so that they may understand health and naturopathic medicine and in turn educate others

The staff of this office appreciates you taking the time to convey this vital information. Please be assured we will do everything possible to assist you in your recovery.

Please return completed forms to the office.

Thank you for your co-operation!!