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		Diptheria	
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	
Stuffiness		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	
Hemmorroids		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 frecency	
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.