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Essential Health Natural Wellness Clinic

New Patient Intake Form

Date: _____

Note: this is a confidential record of your medical history and will be kept in this office. Information contained here or recorded during the consultation will not be released to any person except when you have authorized in writing to do so. Please complete the questionnaire as thoroughly as possible.

Name: _____

Gender: _____

Date of Birth: _____

Occupation: _____

Address: _____

Employer: _____

City: _____

Home Phone: _____

Postal Code: _____

Cell Phone: _____

Marital Status: _____

Email Address: _____

How did you hear about our clinic? _____

Health Priorities/Chief Concerns:

List your main health concerns in order of importance

1. _____

2. _____

3. _____

4. _____

5. _____

6. _____

Medical History:

How would you describe your general state of health? (circle one)

Excellent

Good

Fair

Poor

Please indicate any serious illnesses, surgeries or past hospitalizations:

Surgery/Hospitalization	Date of Diagnosis	Is the condition still present?	Symptoms

Please list any car accidents or other accidents:

Type of Accident	Date of Accident	Injury Sustained	Chronic Issues

Please list all current medications:

Medications	Dose	Prescribing Physician	Length of Use

Please list all current supplements:

Supplements	Dose	Brand	Length of Use

Please indicate any allergies:

Allergy	Symptoms

How many times have you taken antibiotics within the last 5 years? _____

Were you frequently given antibiotics as a child? _____

Have you had any adverse reactions from any vaccinations? _____

Do you get a yearly flu vaccination? _____

Do you use any of the following?

Type	Circle One	How much/How often/Form
Alcohol	Yes No	
Tobacco	Yes No	
Caffeine	Yes No	
Recreational Drugs	Yes No	
Laxatives	Yes No	
Antacids	Yes No	

Please indicate any other medical providers:

Type of Medical Provider	Name

Family History:

Indicate if any family member has had any of the following:

Illness	Circle One	Family Member/Type
Allergies	Yes No	
Asthma	Yes No	
Diabetes	Yes No	
Heart Disease	Yes No	
High Blood Pressure	Yes No	
Kidney Disease	Yes No	
Cancer	Yes No	
Depression	Yes No	
Other mental illness	Yes No	
Thyroid Conditions	Yes No	
Obesity	Yes No	
Other	Yes No	

Lifestyle:

Do you exercise? _____ How often? _____

What type of exercise do you do? _____

Have you recently gained or lost weight? (circle one) YES/ NO _____ lbs.

Current Weight _____ Ideal Weight _____

Do you eat 3 meals per day? _____ Do you skip meals? _____

How many meals do you eat out per week? _____

Which of the following foods do you consume regularly?

- Pop
- Diet pop
- Refined sugar
- Fast food
- Gluten (wheat, rye, barley)
- Dairy (milk, cheese, yogurt)

Typical Food Intake:

Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Drinks: _____

What are your biggest challenges with nutrition?

Sleep Patterns:

Are you satisfied with your sleep? _____ Do you nap? _____

Average hours of sleep per night? _____ Do you wake up in the night? _____

Do you fall asleep within 30 minutes? _____ Do you feel well rested? _____

Mental Health:

How are your moods in general? Do you experience more anxiety, depression or anger than you would like?

On a scale of 1-10, one being the worst and ten being the best, describe your usual level of energy. _____

Do you experience energy crashes in the day? _____

On a scale of 1-10, one being the worst and ten being the best, describe your current level of stress _____

What are the main sources of stress in your life?

Digestion:

Do you have regular daily bowel movements? _____

Bowel Movement Consistency

- | | |
|---|---|
| <input type="checkbox"/> soft & well formed | <input type="checkbox"/> thin, long or narrow |
| <input type="checkbox"/> often float | <input type="checkbox"/> small and hard |
| <input type="checkbox"/> difficult to pass | <input type="checkbox"/> loose but not watery |
| <input type="checkbox"/> diarrhea | <input type="checkbox"/> alternating between hard and loose |

Do you experience intestinal gas and/or bloating? _____

Check any of the conditions that you are currently experiencing.

<p><u>General</u> Numbness/tingling Fainting Dizziness Fatigue Chronic pain Difficulty losing weight Other _____</p> <p><u>Head/Neck</u> Headaches Migraines Vision problems Earaches Decreased hearing Sinus problems Difficulty swallowing Other _____</p> <p><u>Dermatological</u> Eczema/Psoriasis Itching Bruise easily Dryness Boils Hives Acne Cold sores Hair loss Weak finger nails Other _____</p> <p><u>Respiratory</u> Frequent colds/flu Chronic cough Shortness of breath Smoking Breathing problems Asthma/Bronchitis Pneumonia Seasonal Allergies Other _____</p>	<p><u>Cardiovascular</u> Blood pressure issues Chest pain Stroke Varicose veins Swelling of the ankles Poor circulation Heart disease Palpitations High Cholesterol Diabetes Other _____</p> <p><u>Gastrointestinal</u> Poor digestion Indigestion Stomach ulcer Belching Gas/Bloating Nausea/vomiting Abdominal pain Constipation Diarrhea Hemorrhoids Liver concerns Gall bladder issues or stones Other _____</p> <p><u>Musculoskeletal</u> Osteoarthritis Rheumatoid Arthritis Osteoporosis Painful joints Back pain Neck pain Injury Other _____</p> <p><u>Genitourinary</u> Difficulty urinating Bladder infections Kidney stones Prostate issues Other _____</p>	<p><u>Mental/Emotional</u> Depression Anxiety Insomnia Mood swings Panic attacks Irritability Chronic stress Easily overwhelmed Memory issues Brain fog Other _____</p> <p><u>Women's Health</u> Painful menstruation Excessive flow Clots Irregular cycles PMS Cramps or backache Vaginal discharge Painful breasts Lumps in the breast Fertility issues Chronic yeast infections # of pregnancies # of children Other _____</p> <p><u>Menopause</u> Hot flashes Night sweats Vaginal dryness Loss of libido Fatigue Weight gain Depression Anxiety Insomnia Other _____</p>
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What are your desired health goals?

1. _____
2. _____
3. _____
4. _____

Please use this space to add any other information about yourself that you think will be of help to us.

Helping you heal naturally

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