Dr. Sherif Guirguis, ND, MSc, MBBCh
Naturopathy & Acupuncture

INTELLIGENT HEALTH GROUP

PATIENT INTAKE FORM

Full Name	First: Last:
Date of Birth	Day: Month: Year:
Age	
Gender	At birth: Current:
Address	Street: Unit #: City/Town: Province: Postal code:
Telephone	Home: Work: Cell:
Email address	
Occupation	
Marital Status	Single: ☐ Married: ☐ In a relationship: ☐ Widowed: ☐ Divorced: ☐
Body Build	Current Height: Feet Inches or cm Current Weight: Pounds or Kg Weight 1 year ago: Pounds or Kg Highest weight reached: Pounds or Kg
Family Doctor	Name: Telephone:
Emergency Contact	Name: Relation: Telephone:

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CHIEF CONCERNS / MAIN COMPLAINTS

Please list in order of priority, which health areas you would like help improving

Complaint	Start date	Frequency	Severity	Worse with	Better with
e.g. Back Pain	e.g. last week	e.g. On and off or all the time	e.g. 5 out of 10	e.g. Activity	e.g. Rest
1.					
2.					
3.					
4.					

Additional Information: please feel free to add more details about your main health concerns & for each please let me know what your target or expectations of treatment are.

MEDICAL HISTORY

Please write any medical conditions you have been diagnosed with & Date of diagnosis:

Medical condition	Date of diagnosis
1.	
2.	
3.	
4.	
5.	

MEDICATIONS (Prescription or over the counter)

Please list all medications (and their doses) you are currently taking & for each of them please specify for which condition the medication is taken for, how long have you been taking it & related side effects if any:

Medication & dose	Condition	Date Taken since	Adverse effects
1.			
2.			
3.			
4.			
5.			

NATURAL HEALTH PRODUCTS (NHP)

(SUPPLEMENTS/ HERBAL MEDICINES/ HOMEOPATHIC REMEDIES)

Please list all natural health products: including nutritional supplements (like vitamins or minerals), herbal medicines (like Curcumin or Berberine) & / or homeopathic remedies (like Natmur) you are currently taking & for each of them please specify the dose, for which condition it is taken for, how long have you been taking it & related side effects if any:

NHP & dose	Condition	Date Taken since	Adverse effects
1.			
2.			
3.			
4.			
5.			

ALLERGIES/ INTOLERANCES/ SENSITIVITIES

If you have ever suffered from any allergies (e.g. to pollens), intolerances (e.g. to dairy or gluten) or sensitivities (e.g. to ultraviolet light), please specify the underlying cause or trigger (e.g. Food, Medication or Environmental allergen) as well as associated symptoms during the attack (e.g. shortness of breath or loose stools) & severity (e.g. is it so severe to the point of an admission to the emergency room or to the hospital was needed?)

Trigger or Cause	Associated symptoms during attack	Severity
1.		
2.		
3.		
4.		
5.		

SURGICAL HISTORY

If any surgical operation has been done for you, please specify the name of the procedure (e.g. removal of the appendix), date of the procedure & complications if any (e.g. infected surgical wound):

Surgical operation	Date	Complications
1.		
2.		
3.		
4.		

ACCIDENT HISTORY

If you were subject to an accident, please specify the nature of the accident (e.g. car accident or a fall), date of the accident & any residual disabilities (physical e.g. limbing or pain &/ or mental e.g. post-traumatic stress disorder):

Nature of the accident	Date	Related Disabilities
1.		
2.		
3.		
4.		

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FAMILY MEDICAL HISTORY

Please write any medical conditions your family members may have. This includes parents, grandparents, siblings, and children.

Family Member	Conditions

HEALTH HABITS

Any dietary restrictions?	☐ Yes ☐ No If yes, please specify:
24-hour diet recall (in a typical day, not in a weekend or event day)	Please specify the time & the food eaten in each meal: Breakfast @ : 1st snack @ : Lunch @ : 2nd snack @ : Dinner @ : Bedtime snack @ :
Water intake (Coffee, tea, soda does NOT count towards it)	Please specify how many cups /day or litres / day of water
Exercise Habits	How many times do you exercise per week? How long each time? What kind of activity?
Substance Use	How many cups of **coffee** per day? How many cups of **tea** per day? How many cups of **soda** per day? How many cups of **juice** per day? How many **alcoholic** drinks **per week**? Do you **currently smoke**? If yes, how many cigarettes per day? If yes, for how long? Have you **smoked in the past**? If yes, how many cigarettes per day? If yes, for how long?

	Do you use recreational drugs? ☐ Yes ☐ No If yes, what kind? How much? How frequent?
Sleep	How many hours of sleep do you get per night? Are there any difficulties falling asleep? ☐ Yes ☐ No If yes, how long does it take you to fall asleep? Are there any difficulties maintaining sleep? ☐ Yes ☐ No If yes, how many times do you wake up at night? If yes, how long does it take you to fall asleep again? Do you wake up unrefreshed? Tired? ☐ Yes ☐ No If yes, how many times per week? Has your partner noticed that you are snoring at night? ☐ Yes ☐ No If yes, have you ever been diagnosed with sleep apnea? Has your partner or you noticed that your legs twitch or kick during sleep? ☐ Yes ☐ No If yes, have you ever been diagnosed with restless leg syndrome?
Energy	What is your energy level? with ☐ 1 =worst, ☐ 10 =best? Is it the same all the time or variable? When is worst? When is it best?
Stress	What is the biggest source of stress in your life? Are you able to handle your stress? What do you do to keep it under control? Do you have a supportive relationship?

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REVIEW OF BODY SYSTEMS

Please **X** the appropriate answer:

Yes = A condition you are experiencing now.

No = A condition you have never had.

Past = A condition you have had in the past.

Skin and Hair	Yes	No	Past	Eyes	Yes	No	Past
Acne	☐	☐	☐	Do you wear glasses/ contacts?	☐	☐	☐
Hives	☐	☐	☐	Impaired vision/ blurring	☐	☐	☐
Itching/ rashes/ eczema	☐	☐	☐	Cataracts	☐	☐	☐
Psoriasis	☐	☐	☐	Floaters	☐	☐	☐
Excessive hair loss/ growth	☐	☐	☐	Glaucoma	☐	☐	☐
Changes in moles (size/ color)	☐	☐	☐	Macular degeneration	☐	☐	☐
Ear, Nose and Throat	**Yes**	**No**	**Past**	**Respiratory**	**Yes**	**No**	**Past**
Frequent ear infections	☐	☐	☐	Cough	☐	☐	☐
Impaired hearing	☐	☐	☐	Pain on breathing	☐	☐	☐
Tinnitus/ ringing in the ears	☐	☐	☐	Shortness of breath	☐	☐	☐
Ruptured ear drum	☐	☐	☐	Asthma/ wheezing	☐	☐	☐
Excess ear wax	☐	☐	☐	Frequent chest infections	☐	☐	☐
Frequent nose bleeds	☐	☐	☐	Emphysema	☐	☐	☐
Stuffed Nose or sinus	☐	☐	☐	Pneumonia	☐	☐	☐
Allergies	☐	☐	☐	Tuberculosis	☐	☐	☐
Frequent colds/ sore throats	☐	☐	☐	**Musculoskeletal**	**Yes**	**No**	**Past**
Hoarseness	☐	☐	☐	Joint pain/ stiffness	☐	☐	☐
Bleeding gums/ mouth	☐	☐	☐	Back pain	☐	☐	☐
Mercury dental fillings	☐	☐	☐	Sciatica/ nerve pain	☐	☐	☐
Lumps/ swollen glands in neck	☐	☐	☐	Carpal tunnel syndrome	☐	☐	☐
Thyroid nodules	☐	☐	☐	Osteoporosis	☐	☐	☐
Gastrointestinal	**Yes**	**No**	**Past**	Muscle cramps/ weakness	☐	☐	☐
Nausea or vomiting	☐	☐	☐	**Cardiovascular**	**Yes**	**No**	**Past**
Acid reflux or regurgitation	☐	☐	☐	Chest pain/ angina	☐	☐	☐
Indigestion	☐	☐	☐	Heart Disease	☐	☐	☐
Peptic ulcer	☐	☐	☐	Irregular heartbeat	☐	☐	☐

Gallbladder stones/ removal				Palpitations			
Blood in stool				High blood pressure			
Bloating/ Flatulence/ Gas				High cholesterol			
Hernia				Coldness of hands/ legs/ feet			
Hemorrhoids/ piles				Leg pain/ cramps			
Diarrhea				Leg swelling/ edema			
Constipation				Varicose veins			
Neurological	**Yes**	**No**	**Past**	**Mental/ Emotional**	**Yes**	**No**	**Past**
Headaches/ migraines				Anxiety			
Fainting/ loss of consciousness				Bipolar Disorder/ mood swings			
Numbness/ tingling				Depression			
Paralysis/ weakness				Obsessive thoughts			
Slurred speech				Phobias			
Loss of sensation				Suicidal thoughts			
Seizures				Insomnia			
Loss of memory				Treated for substance abuse			
Endocrine	**Yes**	**No**	**Past**	**Endocrine**	**Yes**	**No**	**Past**
Low iron/ other blood disorder				Excessive thirst or hunger			
Unusual fatigue				Diabetes			
Feeling “wired but wired”				Low blood sugar			
Sensitivity to hot or cold				Thyroid problems			
Hot flushes				Excessive sweating/ urination			
Women’s Health	**Yes**	**No**	**Past**	**Women’s Health**	**Yes**	**No**	**Past**
Breast lumps/ nipple discharge				Are you sexually active?			
Breast cancer				Do you use birth control?			
Breast pain or tenderness				Birth control pill			
Premenstrual syndrome				Barrier method			
Irregular menstruation				Natural family planning			
Pain with menstruation				Tubal ligation			
Endometriosis				Abnormal PAP test			
Vaginal itching/ discharge				Number of pregnancies			
Yeast/ Candida infections				Number of live births			
Pain on intercourse				Number of abortions			

Ovarian cysts	☐	☐	☐	Age of first period	☐	☐	☐
Infertility	☐	☐	☐	Date of last period	☐	☐	☐
Menopausal symptoms	☐	☐	☐		☐	☐	☐
Hormone replacement therapy	☐	☐	☐	Family history of breast cancer	☐	☐	☐
Men's Health	**Yes**	**No**	**Past**	**Men's Health**	**Yes**	**No**	**Past**
BPH – enlarged prostate Difficulty urinating	☐	☐	☐	Erectile dysfunction	☐	☐	☐
Prostate cancer	☐	☐	☐	Penile lesions or discharge	☐	☐	☐
Testicular pain/ masses	☐	☐	☐	Problems with sperm count	☐	☐	☐
Urinary	**Yes**	**No**	**Past**	**Urinary**	**Yes**	**No**	**Past**
Kidney disease	☐	☐	☐	Frequent infections	☐	☐	☐
Kidney stones	☐	☐	☐	Blood in urine	☐	☐	☐
Gout	☐	☐	☐	Difficulty urinating	☐	☐	☐
Incontinence	☐	☐	☐	Pain or burning in urine	☐	☐	☐

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CONSENT TO NATUROPATHIC MEDICAL CARE

(to be reviewed by the patient & signed either electronically now or manually during the initial in-person visit)

Patient Name:	
Date of Birth:	

I hereby consent to my Naturopathic Doctor: **Dr. Sherif Guirguis, ND** to treat me for the purposes I have indicated on my Client Intake form. I consent to any assessments, physical examinations and techniques which may be recommended by my Naturopathic Doctor. This can also include acupuncture, as seen fit and mutually agreed upon.

I acknowledge and understand that the Naturopathic Doctor must be fully aware of my existing medical conditions. I have completed my medical history form as provided by my Naturopathic Doctor and have disclosed all medical conditions affecting me. It is my responsibility to keep my Naturopathic Doctor updated on my medical history. The medical information I have provided is true and complete to the best of my knowledge. I authorize my Naturopathic Doctor to release or obtain information pertaining to/from my other caregivers or third-party payers.

I have read the above noted consent, and I have had the opportunity to question the contents of my treatment. By signing this form, I confirm my consent to Naturopathic medical care and intend this consent to cover the treatment discussed, as well as any other treatment proposed by my Naturopathic Doctor. I understand that I may withdraw my consent for future treatment at any time and my treatment will then be discontinued.

Patient Name	**Patient Signature**	**Date**
Witness Name	**Witness Signature**	**Date**