Dr Laura Brass BSc ND
Naturopathic Doctor #1680
236 Avenue Rd. Suite 200
Toronto, ON, M5R 2J4

T: 416 922 2000
F: 416 922 2005
drlaurabrass.com

PATIENT INTAKE FORM

GENERAL

First name:		Last name:
Age:	Date of Birth: / /	Gender:
Address:		
City:		Province:
Postal code:		Phone (H):
Phone (W):		Email:
Occupation:		Place of work:
Marital status/Living arrangement:		
Number of children:		Ages:

EMERGENCY CONTACT

Name:	Relationship:
Phone (H):	Phone (W):

HEALTH CARE PROVIDERS

Family Physician:	Phone:
Other provider:	Phone:

How would you like to be reminded of your appointments?

☐ Phone call ☐ Email ☐ Don't send reminders

Have you seen a Naturopathic Doctor before? _____

How did you hear about Dr Brass? _____

☐ Would you like to subscribe to our newsletter?

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HEALTH CONCERNS

Reason for visit (list in order of importance)	Date of onset
1.	/ /
2.	/ /
3.	/ /
4.	/ /

How would you rate your current state of health?

☐ Excellent ☐ Good ☐ Fair ☐ Poor

Current vitamins, minerals, supplements, or herbal products (brands and dosages):

Current medications and dosages (including over-the-counter):

Past medications:

How many times have you been treated with antibiotics?

List any known allergies:

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LIFESTYLE

Reversing illness by treating the underlying cause of disease, and effectively managing healthcare does not happen overnight. It requires a commitment to lifestyle change, and following therapeutic protocols.

Please circle your present level of commitment to making changes in your health:

0 10 20 30 40 50 60 70 80 90 100%

Please circle the level of stress you are experiencing. (1 being the least):

1 2 3 4 5 6 7 8 9 10

What are the major sources of stress in your life (financial, job, family, etc)?

What behaviors or lifestyle habits do you currently engage in regularly that you believe support your health?

What behaviors or lifestyle habits do you currently engage in regularly that you believe are detrimental to your health?

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DIGESTION

How many bowel motions do you have in a typical day? _____

Do you experience any of these digestive symtoms regularly?	
☐ Bloating	☐ Heartburn
☐ Gas	☐ Indigestion

What is the general form of your stool?

☐	Type 1		Separate hard lumps, like nuts (hard to pass)
☐	Type 2		Sausage-shaped but lumpy
☐	Type 3		Like a sausage but with cracks on the surface
☐	Type 4		Like a sausage or snake, smooth and soft
☐	Type 5		Soft blobs with clear-cut edges
☐	Type 6		Fluffy pieces with ragged edges, a mushy stool
☐	Type 7		Watery, no solid pieces, entirely liquid

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DIET

FOOD	Please list what you eat in a typical day
Breakfast	
Lunch	
Dinner	
Snacks	

BEVERAGES	Amount	**BEVERAGES**	Amount
☐ Water		☐ Tea	
☐ Coffee		☐ Herbal tea	
☐ Soft drinks		☐ Alcohol	
☐ Juices		☐ Other	

SLEEP

☐ Wake feeling rested	☐ 8-10 hours per night	☐ Sleep through night
☐ Wake feeling tired	☐ 6-8 hours per night	☐ Difficulty falling asleep
☐ Reliance on medication	☐ Less than 6 hrs/night	☐ Difficulty staying asleep

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What potential obstacles do you anticipate in addressing the lifestyle factors that are undermining your health?

Do you have people who will sincerely and consistently support you with the beneficial lifestyle changes you will be making? If so, whom?

What expectations do you have of me as your Naturopathic Doctor?

MEDICAL HISTORY

Please list all major hospitalizations, surgeries, injuries, diseases, and traumatic events, and the year of onset (continue on back if necessary):

Event/disease	Date of onset
1.	/ /
2.	/ /
3.	/ /
4.	/ /

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HEALTH HISTORY

Past	Present		Past	Present		Past	Present	
		MEDICAL	☐	☐	Seasonal depression	☐	☐	TMJ problems
☐	☐	Allergies	☐	☐	Sexually transmitted infection	☐	☐	Vision problems
☐	☐	Alcoholism / Drug addiction			**GENERAL**			**SKIN**
☐	☐	Alzheimer's disease	☐	☐	Dizziness	☐	☐	Acne
☐	☐	Anxiety	☐	☐	Fainting	☐	☐	Boils/hives
☐	☐	Cancer	☐	☐	Fever	☐	☐	Bruise easily
☐	☐	Chronic fatigue	☐	☐	Frequent colds/flu	☐	☐	Dryness
☐	☐	Cholesterol, elevated	☐	☐	Insomnia	☐	☐	Itching
☐	☐	Depression	☐	☐	Loss of consciousness	☐	☐	Rashes/eczema
☐	☐	Eating disorder	☐	☐	Night sweats	☐	☐	Psoriasis
☐	☐	Environmental sensitivities	☐	☐	Numbness/tingling			**RESPIRATORY**
☐	☐	Epilepsy	☐	☐	Sweats	☐	☐	Asthma/bronchitis
☐	☐	Fibromyalgia	☐	☐	Weight loss	☐	☐	Chronic cough
☐	☐	Genetic disorder			**HEAD AND NECK**	☐	☐	Emphysema
☐	☐	Infection, chronic	☐	☐	Dental problems	☐	☐	Pneumonia
☐	☐	Learning disabilities	☐	☐	Difficulty swallowing	☐	☐	Smoking
☐	☐	Mental illness	☐	☐	Earaches			**CARDIOVASCULAR**
☐	☐	Neurological problem	☐	☐	Glaucoma	☐	☐	Bleeding disorder
☐	☐	Obesity	☐	☐	Headaches	☐	☐	Blood pressure issues
☐	☐	Osteoporosis	☐	☐	Sinus problems	☐	☐	Chest pain

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HEALTH HISTORY

Past	Present		Past	Present		Past	Present	
☐	☐	Circulation problems			**URINARY**			**ILLNESSES/INFECTIONS**
☐	☐	Heart disease	☐	☐	Bladder trouble	☐	☐	Chicken pox
☐	☐	Stroke	☐	☐	Blood in urine	☐	☐	Diphtheria
☐	☐	Swollen ankles	☐	☐	Kidney/bladder disease	☐	☐	Mumps
☐	☐	Varicose veins	☐	☐	Urinary tract infection	☐	☐	German measles
		GASTROINTESTINAL			**MEN**	☐	☐	Hepatitis
☐	☐	Abdominal pain	☐	☐	Enlarged prostate	☐	☐	Herpes
☐	☐	Constipation	☐	☐	Infertility	☐	☐	HIV/AIDS
☐	☐	Crohn's & Colitis	☐	☐	Prostate cancer	☐	☐	Measles
☐	☐	Diarrhea			**WOMEN**	☐	☐	Rheumatic fever
☐	☐	Diverticular disease	☐	☐	Birth control pill	☐	☐	Scarlet fever
☐	☐	Excessive hunger	☐	☐	Breast cancer	☐	☐	Shingles
☐	☐	Food intolerance	☐	☐	Endometriosis	☐	☐	Tuberculosis
☐	☐	Gallstones	☐	☐	Fibroids/ovarian cysts			**MUSCLES/JOINTS**
☐	☐	GERD	☐	☐	Infertility	☐	☐	Back pain
☐	☐	Heart burn	☐	☐	Lumpy breasts	☐	☐	Carpel tunnel syndrome
☐	☐	Hemorrhoids	☐	☐	Menstrual irregularites	☐	☐	Elbow pain L/R
☐	☐	Indigestion	☐	☐	PCOS	☐	☐	Foot pain L/R
☐	☐	Inflammatory bowel	☐	☐	PMS	☐	☐	Hip pain
☐	☐	Liver concerns	☐	☐	Vaginal infection	☐	☐	Knee pain

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HEALTH HISTORY

Past	Present		IMMUNIZATIONS		
		Neck pain		Chicken pox	Hepatitis B
		Shoulder pain L/R		Diphtheria, Pertussis, Tetanus	Hepatitis C
		Swollen joints/arthritis		Flu shot	Measles, Mumps, Rubella
		Weakness		Haemophilus Influenza B	Polio
		Wrist pain		Hepatitis A	Smallpox
					Tetanus booster

FAMILY HISTORY

Have any of your family members experienced these conditions?

Alzheimer's disease	Diabetes	Mental illness
Arthritis	Drug addiction	Migraine headaches
Asthma	Eczema	Psoriasis
Autoimmune (MS, Lupus, etc)	Heart disease	Stroke
Cancer _____	High blood pressure	Thyroid issues
Depression	Kidney disease	Other _____

WOMEN

Age of first period:	Date of last menstrual cycle:
Number of past pregnancies:	Number of days with menses:
Number of children:	Length of menstrual cycle:

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ADDITIONAL INFORMATION

Is there anything else you feel I should know about you?