Client Intake Form

Title:	Given name:	Surname:
Preferred name:		
Address:		
Mailing Address:		Post code:
Phone (Home):		(Mobile):
Phone (Work):		Email:
D.OB.:	Gender:	Occupation:
Emergency contact:		Phone:
Family doctor:		Phone:

Referred by: General practitioner ☐ Alternative medical practitioner ☐ Family/Friend ☐ Advertising material (leaflet) ☐ Other ☐

Please tell us what health issues you wish to address today /what naturopathic support you are interested in.

Have you had any major health issues in the past? Please summarise any information you wish to share.

Do you smoke? If yes, how many per day?

Have you ever smoked? If yes, when did you quit?

Are you pregnant? If yes, when is your due date?

ALLERGIES/INTOLERANCES (Please mark)

☐ Dairy products	☐ Medicines	☐ Pollen
☐ Soy products	☐ Nuts	☐ Pets
☐ Wheat	☐ Eggs	☐ Other

If medicines or other – please specify:

Have these allergies been formally diagnosed? If so, when?

CURRENT MEDICINES AND SUPPLEMENTS (Please include over the counter medications and those prescribed by a medical or natural medicine practitioner)

NAME OF MEDICINE	DOSAGE PER DAY	SINCE WHEN?	REASON FOR TAKING?
NAME OF SUPPLEMENT	DOSAGE PER DAY	SINCE WHEN?	REASON FOR TAKING?

Is there anything else that you would like to include on this form?

Name: (Client/Parent, Legal Guardian*)	Signed:	Date:

*If applicant is under the age of 18

Practitioner Name:	Signed:	Date: