Jeremy Toman, ND
(519) 889-1718
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Jeremy Toman ND
Viable Healthcare with Natural Options.

Located inside Total Body Wellness
110 Durham St E Suite 2
Walkerton, Ontario

Adult Patient Intake – First Visit

General Information

Patient name:__________________________________ **Today's Date:** _________________
Date of birth:_______/_________/________ (D/M/Y) **Gender:** ___________________
Address:____

Unit/Street number Street City Postal Code

Marital Status: __________________ **Religion/Spirituality:**_________________________

Telephone number: Home:______________________ **Work**:_______________________

E-mail address: ________________________________ **Cell:** ________________________

Would you like a email reminder for your appointments? Y / N

May we leave messages on your answering machine or with any immediate member of your household? Y / N **How did you first hear about the Clinic?**:_________________________
How many times did you hear about the clinic before you made an appointment?_________________
Do you have extended health benefits? Company________________ **Policy Number** _______________

Emergency contact

Name: ____

Phone number:__________________________ **Relation**:_____________________________

Other health care providers you are seeing:

Name: _____________________	Name:_____________________	Name:_____________________
Specialty ___________________	Specialty:___________________	Specialty___________________
Ph (______)__________________	Ph (______)__________________	Ph(______)__________________
Date of Last Visit:____________	Date of Last Visit:__________ __	Date of Last Visit:__________ _

Please list your health concerns, and date of onset in order of importance to you:

1. ____
2. ____
3. ____
4. ____
5. ____

Medical History

How would you describe your general state of health? Excellent Good Fair Poor

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Please indicate all past or current significant medical conditions, previous illnesses, significant injuries and or hospitalizations. Include approximate dates.

______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________
______________________________ ______________________________

Do you have any allergies or sensitivities(medications, environmental, foods etc.)?

Allergy to	Sensitivity to	Symptoms	Last Reaction?

Please list all *current* prescription or over the counter medications.

Medication	Dose	Reason for taking	How long?

Please list all *current* supplements, herbs, homeopathics, Chinese patents etc.

Supplement	Brand	Dose	Reason for taking	How long?

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Have you ever had any adverse reactions to any medication, supplement, herb or homeopathic?

____

____

Please list all *past* prescription medications, why you were taking them and for how long.

Medication	Dose	Reason for taking	How long?

How many times have you been treated with antibiotics? _________________________________

When was the last time that you had blood work done? __________________________________

Do you have a preference for the type of Naturopathic treatment used?

____

Are there any types of treatments that you would rather not have used?

____

<u>Female Patients</u>

Are you currently or trying to become pregnant? Yes / No

When was your last pap? __________ **Have you ever had an abnormal pap? Y / N**

When was your last breast exam? ____________

What is your method of birth control? ___________________

<u>Expectations</u>

Why did you come to the clinic? What do you know about my approach?

____

____

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What 3 expectations do you have from this first visit?

____
____
____

What are your long term expectations of this clinic?

____
____

What expectations do you have of me personally as your physician?

____
____

What is your current level of commitment to making lifestyle changes that are underlying the cause of your symptoms? (10 = 100% circle one) 1 2 3 4 5 6 7 8 9 10

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

____
____

What behaviours or lifestyle habits do you currently engage in regularly that you believe to be harmful or self-destructive?

____
____

What potential problems do you foresee in addressing the lifestyle factors which are undermining your health and adhering to the therapeutic protocols which I will be sharing with you?

____
____

Who do you know that will sincerely support you consistently with the beneficial lifestyle changes that you will be making?

____
____

What do you <u>LOVE</u> to do?

____
____