**Dr. Sandra Miranda BSc, ND**
*Doctor of Naturopathic Medicine*

Dear Patient:

Thank you for choosing Miranda Naturopathic Clinic for your Health Care Needs. By choosing our clinic, we assure you that you are choosing the highest quality of health care. In order to best help you, we will need to know about your medical history. Please take a few moments to fill in the following questionnaire and the enclosed diet diary before your next appointment.

Your first appointment will take approximately 75 minutes, the second appointment will take 60 minutes and subsequent appointments (progress checks) will take approximately 20 to 30 minutes. During the first visit, an in-depth health history is taken in order to understand all factors that may be affecting you. The visit also includes a physical exam and some diagnostic tests, for example; urinalysis, Body Composition Test, Vitamin C Urine Test, Bowel Toxicity Urine Test and zinc status. Further laboratory testing may be discussed and performed if indicated. All this information will assist us to make a thorough assessment of your condition. All information will remain completely confidential. A personalized treatment plan will then be proposed.

If possible, please arrange, bring, mail or fax all medical test (blood, urine, ultrasound, MRI's and surgery results) pertaining to your health from your physician's office.

As a courtesy to our patients with allergies and for your possible homeopathic treatment, we ask that you do not wear perfume of any kind in the clinic.

Please remember that it takes time to feel better when using naturopathic medicine. You may be a patient who has spent many years with a chronic medical problem unsolved by conventional medicine; or you may be feeling well and want to make adjustments in order to improve your general health. No matter what your reasons are for coming, remember that some patients need to be patient! The more you are able to participate in your own care, the easier it will be to address your health concerns.

1. This is to acknowledge that I have read the above information and understood its contents.
2. I agree to pay my full account at the time of each visit or treatment, including fees for services, laboratory tests or any supplement or remedies I may wish to purchase.
3. I authorize and consent to the treatments I may receive from Sandra Miranda ND of my own free will and choice.
4. I understand that I am at liberty to seek or continue medical care from a physician or health care provider.
5. I am not an agent of any private, local, county, provincial or federal agency attempting to gather information without so stating my intentions first.

_________________________ Patient's Signature

_______________________ Date

Thank you for taking the time and patience to complete this form. We know it is very detailed but it is very important to collect all the details to know "the whole person" and in finding the root cause of your problem. We look forward to working with you and your family in your Naturopathic care.

# INTAKE FORM

## PERONAL DATA

Surname: __________________ First name: _______________ Preferred name/nickname: ____________

Address: ______________________________ City: _______________ Province: ____ P/C: _________

Phone: H – (____) ____-_____ W – (___) ____ - ______ Ext: ____ Where can we leave a message? H W

Email:_________________________ Date of Birth: (mm/dd/yyyy) _________ Age: _____ Sex: F / M

How did you hear about our clinic? _________________________________________________________

Would you like to receive Dr Miranda's Weekly Health Tips via email? Yes No

Other Health Care Providers:

Name: ________________________ Occupation: _________________________ Phone: _____________
Name: ________________________ Occupation: _________________________ Phone: _____________
Name: ________________________ Occupation: _________________________ Phone: _____________

**Emergency contact: Name: _________________ Relationship: ______________ Phone: ___________**

## CHIEF HEALTH CONCERNS

Indicate your main health concern(s) – In order of importance to you. For how long have you had this problem?

1.__________________________________________________ ______________________________
2.__________________________________________________ ______________________________
3.__________________________________________________ ______________________________
4.__________________________________________________ ______________________________
5.__________________________________________________ ______________________________
6.__________________________________________________ ______________________________

## HEALTH STATUS

Current weight: ___________ Ideal Weight: ____________ Maximum Weight: _________ When: __________

What do you usually eat and drink for:
Breakfast: ______________________________________________________________________________
Lunch: ______________________________________________________________________________
Dinner: ______________________________________________________________________________
Snacks: ______________________________________________________________________________
Beverages: ______________________________________________________________________________

How many antibiotic treatments have you received? 0 – 5 times 6 – 13 times more than 13 times

List any medications/supplements that you have taken or are currently taking. (P = past / C = current)

| Starting Age | P/C | Medication/Supplement | Illness | Adverse Reactions |
|---|---|---|---|---|
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |
| | | | | |

## SOCIAL ENVIRONMENT

How often do you do the following?:
Smoke Cigarettes ___________________ Drink Coffee _____________________ Drink Alcohol ________________
Drink Water ______________________ Use Recreational Drugs _________________ Which one(s): ____________

Indicate the emotional climate of your home: Very stable Stable Stressful Very Stressful
Comments:________________________________________________________________________________________________

Indicate if any of the members living in your household smoke: Yes/No

How many hours per week do you exercise? None 1 – 3 hrs 4 – 6 hrs more than 6 hours

How many hours of sleep, on average, do you get each night? Less than 6 6 – 8 hrs more than 8 hrs

How many hours do you work per week? None 1 – 8 hrs 8 –16 hrs more than 16 hours

If sexually active, please answer the following two questions:
Form of contraceptions used:
Birth Control Pill Condom Diaphragm IUD Sponge Cervical Cap Other ______________

Indicate if you have or have had any sexually transmitted diseases:
Gonorrhea Chlamydia HIV Human Papillomavirus Hepatitis B Other_______________

## FAMILY HEALTH HISTORY

Indicate if anyone in your family has had any of the following health problems:

| Health Problem | Relationship to the patient | Age of onset | For how long | Cause of death (if applicable) |
|---|---|---|---|---|
| Hypertension | | | | |
| | | | | |
| Cancer | | | | |
| | | | | |
| Diabetes | | | | |
| | | | | |
| Asthma | | | | |
| | | | | |
| Allergies | | | | |
| | | | | |
| Heart Problems | | | | |
| | | | | |
| Other | | | | |
| | | | | |

## REVIEW OF SYSTEMS

**If you have had any of the conditions below, please circle "P" for past and "C" for current.**

**SKIN**

| | | | |
|---|---|---|---|
| Acne, boils | Yes | (P/C) | No |
| Psoriasis | Yes | (P/C) | No |
| Eczema/hives | Yes | (P/C) | No |
| Excessive dryness | Yes | (P/C) | No |
| Itching | Yes | (P/C) | No |
| Rashes | Yes | (P/C) | No |
| Tendency to bruise | Yes | (P/C) | No |
| Change in moles | Yes | (P/C) | No |
| Colour changes | Yes | (P/C) | No |
| Nail/Hair changes | Yes | (P/C) | No |
| Night sweats | Yes | (P/C) | No |

**EYES**

| | | | |
|---|---|---|---|
| Blind spots | Yes | (P/C) | No |
| Cataracts | Yes | (P/C) | No |
| Redness | Yes | (P/C) | No |
| Double vision | Yes | (P/C) | No |
| Excessive tearing | Yes | (P/C) | No |
| Eye infections | Yes | (P/C) | No |
| Eye pain | Yes | (P/C) | No |
| Impaired vision | Yes | (P/C) | No |
| Itching | Yes | (P/C) | No |

### MOUTH AND THROAT

| | | | |
|---|---|---|---|
| Dental cavities | Yes | (P/C) | No |
| Frequent bad breath | Yes | (P/C) | No |
| Frequent sore throat | Yes | (P/C) | No |
| Gum bleeding | Yes | (P/C) | No |
| Hoarseness | Yes | (P/C) | No |
| Loss of taste | Yes | (P/C) | No |
| Toothaches | Yes | (P/C) | No |
| Sore tongue | Yes | (P/C) | No |
| Thrush | Yes | (P/C) | No |
| Times patient brushes daily | ________ | | |
| Last visit to dentist | ________ | | |

### HEAD

| | | | |
|---|---|---|---|
| Dizziness | Yes | (P/C) | No |
| Head lice | Yes | (P/C) | No |
| Headache | Yes | (P/C) | No |
| Injury | Yes | (P/C) | No |
| Meningitis | Yes | (P/C) | No |

### NECK

| | | | |
|---|---|---|---|
| Difficult in holding head | Yes | (P/C) | No |
| Limitation of movement | Yes | (P/C) | No |
| Lumps | Yes | (P/C) | No |
| Pain or stiffness | Yes | (P/C) | No |
| Thyroid enlargement | Yes | (P/C) | No |

### EARS

| | | | |
|---|---|---|---|
| Discharge | Yes | (P/C) | No |
| Dizziness | Yes | (P/C) | No |
| Earache | Yes | (P/C) | No |
| Impaired hearing | Yes | (P/C) | No |
| Infections | Yes | (P/C) | No |

### NOSE AND SINUSES

| | | | |
|---|---|---|---|
| Frequent colds | Yes | (P/C) | No |
| Hay fever | Yes | (P/C) | No |
| Loss of sense of smell | Yes | (P/C) | No |
| Nose bleeds | Yes | (P/C) | No |
| Sinus problems | Yes | (P/C) | No |
| Stuffiness | Yes | (P/C) | No |

### GASTROINTESTINAL

| | | | |
|---|---|---|---|
| Abdominal Pain | Yes | (P/C) | No |
| Blood in stools | Yes | (P/C) | No |
| Change in bowel habits | Yes | (P/C) | No |
| Change in thirst | Yes | (P/C) | No |
| Change in appetite | Yes | (P/C) | No |
| Constipation | Yes | (P/C) | No |
| Decreased appetite | Yes | (P/C) | No |
| Diarrhea | Yes | (P/C) | No |
| Flatulence/passing gas | Yes | (P/C) | No |
| Food intolerance | Yes | (P/C) | No |
| Food allergy | Yes | (P/C) | No |
| Hemias | Yes | (P/C) | No |
| Increased appetite | Yes | (P/C) | No |
| Indigestion | Yes | (P/C) | No |
| Jaundice | Yes | (P/C) | No |
| Liver disease | Yes | (P/C) | No |
| Nausea | Yes | (P/C) | No |
| Trouble swallowing | Yes | (P/C) | No |
| Vomiting | Yes | (P/C) | No |
| Vomiting blood | Yes | (P/C) | No |
| Obesity | Yes | (P/C) | No |
| Anorexia Nervosa | Yes | (P/C) | No |
| Bulimia | Yes | (P/C) | No |
| Bowel movts, how often | ________ | | |

### RESPIRATORY

| | | | |
|---|---|---|---|
| Asthma | Yes | (P/C) | No |
| Bronchitis | Yes | (P/C) | No |
| Frequent cough | Yes | (P/C) | No |
| Difficulty breathing | Yes | (P/C) | No |
| Frequent colds | Yes | (P/C) | No |
| Pain on breathing | Yes | (P/C) | No |
| Pneumonia | Yes | (P/C) | No |
| Mononucleosis | Yes | (P/C) | No |
| Shortness of breath at rest | Yes | (P/C) | No |
| Spitting up blood | Yes | (P/C) | No |
| Sputum production | Yes | (P/C) | No |
| Tuberculosis | Yes | (P/C) | No |
| Wheezing | Yes | (P/C) | No |
| Last tuberculin test | ________ | | |
| Date of last X-ray | ________ | | |

### PERIPHERAL

| | | | |
|---|---|---|---|
| Deep leg pain | Yes | (P/C) | No |
| Cold hand/feet | Yes | (P/C) | No |
| Varicose veins | Yes | (P/C) | No |
| Leg cramps | Yes | (P/C) | No |
| Extremity numbness | Yes | (P/C) | No |
| Extremity coldness | Yes | (P/C) | No |
| Extremity ulcers | Yes | (P/C) | No |

### CARDIOVASCULAR

| | | | |
|---|---|---|---|
| Anaemia | Yes | (P/C) | No |
| Chest pain/discomfort | Yes | (P/C) | No |
| Congenital heart problems | Yes | (P/C) | No |
| Cyanosis | Yes | (P/C) | No |
| Fatigue on exertion | Yes | (P/C) | No |
| Heart murmur | Yes | (P/C) | No |
| Palpitation/fluttering | Yes | (P/C) | No |
| Recent transfusion | Yes | (P/C) | No |

### URINARY

| | | | |
|---|---|---|---|
| Blood in urine | Yes | (P/C) | No |
| Change in size of scrotum | Yes | (P/C) | No |
| Frequency at nights | Yes | (P/C) | No |
| Hesitancy | Yes | (P/C) | No |
| Increased frequency | Yes | (P/C) | No |
| Kidney stones | Yes | (P/C) | No |
| Pain on urination | Yes | (P/C) | No |
| Polyuria | Yes | (P/C) | No |

| | | | |
|---|---|---|---|
| Rheumatic fever | Yes (P/C) No | Unpleasant odour of urine | Yes (P/C) No |
| Hypertension | Yes (P/C) No | Urgency/Inability to hold | Yes (P/C) No |
| Blood type | ________________ | Date of last urinalysis | ________________ |
| Date of last blood test | ________________ | Urination, how often? | ________________ |

**FEMALE REPRODUCTIVE**

| | |
|---|---|
| Breast tenderness | Yes (P/C) No |
| Nipple discharge | Yes (P/C) No |
| Vaginitis | Yes (P/C) No |
| Vaginal discharge | Yes (P/C) No |
| Vaginal itching | Yes (P/C) No |
| Endometriosis | Yes (P/C) No |
| Age menses began | ________________ |
| Are cycles regular? | Yes (P/C) No |
| Length of cycle | ________________ |
| Excessive flow | Yes (P/C) No |
| Average number of days | ________________ |
| Bleeding between periods | Yes (P/C) No |
| Painful menses | Yes (P/C) No |
| PMS | Yes (P/C) No |
| Last menstrual period | ________________ |
| Pregnancy, how many | ________________ |
| Abortions, how many | ________________ |
| **Do you need a breast** | **Yes/No**<br>**Initials:** ________ |
| **Do you need an internal** | **Yes/No**<br>**Initials:** ________ |

**MALE REPRODUCTIVE**

| | |
|---|---|
| Discharge or sores | Yes (P/C) No |
| Testicular pain | Yes (P/C) No |
| Testicular masses | Yes (P/C) No |
| Breast enlargement | Yes (P/C) No |
| Hernias | Yes (P/C) No |
| Wet dreams | Yes (P/C) No |
| Varicocele | Yes (P/C) No |
| Age that voice began to deepen | ________________ |
| Age that facial hair first appeared | ________________ |
| Do you need a genital exam? | **Yes/No**<br>**Initials:** ________ |
| Do you need a prostate exam? | **Yes/No**<br>**Initials:** ________ |

**MUSCULOSKETETAL**

| | |
|---|---|
| Abnormal gait | Yes (P/C) No |
| Arthritis | Yes (P/C) No |
| Back or joint stiffness | Yes (P/C) No |
| Backaches | Yes (P/C) No |
| Broken bones | Yes (P/C) No |
| Clumsiness | Yes (P/C) No |
| Deformity | Yes (P/C) No |
| Fractures | Yes (P/C) No |
| Joint swelling | Yes (P/C) No |
| Lack of co-ordination | Yes (P/C) No |
| Muscle pains or cramps | Yes (P/C) No |
| Serious sprains | Yes (P/C) No |
| Weakness | Yes (P/C) No |
| Short stature | Yes (P/C) No |
| Tall stature | Yes (P/C) No |

**NEUROLOGIC**

| | |
|---|---|
| Dizziness | Yes (P/C) No |
| Fainting | Yes (P/C) No |
| Involuntary movements | Yes (P/C) No |
| Loss of memory | Yes (P/C) No |
| Loss of balance | Yes (P/C) No |
| Muscle weakness | Yes (P/C) No |
| Nightmares | Yes (P/C) No |
| Numbness or tingling | Yes (P/C) No |
| Paralysis | Yes (P/C) No |
| Seizure/Convulsions | Yes (P/C) No |
| Speech problems | Yes (P/C) No |
| Tremors | Yes (P/C) No |
| Nervous | Yes (P/C) No |

| ENDOCRINE | | | | EMOTIONAL | | | |
|---|---|---|---|---|---|---|---|
| Diabetes | Yes | (P/C) | No | Panic attacks | Yes | (P/C) | No |
| Excessive thirst | Yes | (P/C) | No | Rage reactions | Yes | (P/C) | No |
| Excessive urination | Yes | (P/C) | No | Fatigue | Yes | (P/C) | No |
| Excessive sweating | Yes | (P/C) | No | Anxiety or nervousness | Yes | (P/C) | No |
| Excessive hunger | Yes | (P/C) | No | Depression | Yes | (P/C) | No |
| Growth hormone therapy | Yes | (P/C) | No | Mood swings | Yes | (P/C) | No |
| Hypoglycemia | Yes | (P/C) | No | Phobias/fears | Yes | (P/C) | No |
| Heat / cold intolerance | Yes | (P/C) | No | Insomnia | Yes | (P/C) | No |
| Salty taste to skin | Yes | (P/C) | No | History of child abuse | Yes | (P/C) | No |
| Signs of early puberty | Yes | (P/C) | No | Suicidal thoughts | Yes | (P/C) | No |

**What else would your like me to know about your health?**

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

**THANK YOU FOR TAKING THE TIME TO FILL OUT THIS INTAKE FORM!**