Dr. Sandra Miranda, ND
Naturopathic Doctor

Dear Patient:

Thank you for choosing the 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 60 minutes but we ask patients to arrive 15 minutes prior to the appointment in order to perform some tests (urinalysis, blood pressure, body composition test) that are included in the initial consultation. During the first visit, an in-depth health history is taken in order to understand all factors that may be affecting you. The follow up visits are 30 minutes long. Further laboratory or functional 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.

MIRANDA NATUROPATHIC CLINIC
10-467 Westney Rd South, Unit 10, Ajax, ON, L1S 6V8
905-239-3900 info@mynaturalclinic.com www.mynaturalclinic.com

INTAKE FORM

PERONAL DATA

Surname: _____ First name: _____ Preferred name/nickname: _____

Address: _____ City: _____ Province: ____ P/C: _____

Phone: Home – (____) _____-_____ Cell – (___) _____ - _____ Where can we leave a message? H / C

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***": YES NO

OTHER HEALTH CARE PROVIDERS:

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._____ _____

HEALTH STATUS

Current weight: _____ Ideal Weight: _____ Maximum Weight: _____ When: _____

What do you usually eat and drink for:
Breakfast: _____

Lunch: _____

Dinner: _____

Snacks: _____

Beverages: _____

ALLERGIES: What are you allergic to? _____

_____

MEDICATIONS / SUPPLEMENTS: (if you need more space, feel free to attach a separate page)
Any medications/supplements that you have taken or are currently taking. (P = past / C = current)

Starting Age	P/C	Medication/Supplement	Illness	Adverse Reactions

MIRANDA NATUROPATHIC CLINIC
10-467 Westney Rd South, Unit 10, Ajax, ON, L1S 6V8
905-239-3900 info@mynaturalclinic.com www.mynaturalclinic.com

On a scale of 1 to 10 (1 being the lowest), rate your: Energy Level _____ Stress Level _____

SLEEP: Do you sleep well? ☐ Yes ☐ No How many hours do you sleep per night? _____

EXERCISE

Frequency: ☐ None ☐ 1 - 2 days per week ☐ 3 - 4 days per week ☐ 5 - 7 days per week

Type: ☐ Walk ☐ Run / Jog / Jump Rope ☐ Swim ☐ Weight Lift ☐ Other _____

HEALTH HABITS:

☐ Alcohol: Wine_____ glasses / day or wk, Liquor_____ oz / day or wk, Beer_____ glasses / day or wk

☐ Caffeine: Coffee _____ cups / day, Tea _____ cups / day, Soda _____ cans/bottles / day

☐ Water _____ glasses / day ☐ Cow's Milk _____ glasses / day ☐ Herbal Tea _____ cups / day

☐ Tobacco: Cigarettes _____ / day, Cigars _____ / day, Date Started _____

☐ Recreational Drugs: Which one:_____ Frequency: _____ per day or wk or month

NUTRITION:

☐ Skip breakfast Number of meals per day _____ Food restrictions _____

☐ Graze (small frequent meals) ☐ Eat constantly (whether hungry or not) ☐ Generally eat on the run

PAST/CURRENT MEDICAL HISTORY: Write on the left side a "P" for PAST or a "C" for Current to anyone that applies:

	Fatigue / low energy		Arthritis		Irregular Periods		Skin problems
	Cancer: Breast		Heart disease / Stroke		PMS (premenstrual synd)		Hypothyroidism
	Cancer: Ovarian		High cholesterol		Heavy/ Painful Periods		Hyperthyroidism
	Cancer: Uterine		High blood pressure		Endometriosis		Hot flashes
	Cancer: Prostate		Low blood pressure		Ovarian cysts		Night sweats
	Depression / Anxiety		Hypoglycemia		Cystic Breasts		Hormones Use
	Diabetes Type 1 or 2		Yeast/Bladder Infections		Hysterectomy		Allergies
	Osteoporosis		Overweight / Obesity		Infertility		Recurrent colds & flus
	Bloating & gassiness		Headaches / migraines		Miscarriages		Autoimmune problems
	Constipation/ Diarrhea		Mood swings		Lactation		Other_____
	Heartburn / GERD		Irritability / Rage		Birth Control Pill or IUD		Other _____

FAMILY MEDICAL HISTORY: Very important to indicate if there is any family history of: cancer, heart problem, stroke, diabetes, high blood pressure, arthritis, autoimmunity, osteoporosis, infertility or any other health concern.

Health problem	Relationship to patient	Age of Onset	Still alive?
			Yes No
			Yes No
			Yes No
			Yes No

We would like to make sure you get the most out of your visits. What would you like to achieve with our treatments?

_____

_____

_____

_____

MIRANDA NATUROPATHIC CLINIC
10-467 Westney Rd South, Unit 10, Ajax, ON, L1S 6V8
905-239-3900 info@mynaturalclinic.com www.mynaturalclinic.com