Infinity Health Inc.
Dr. Alexina Mehta
Naturopathic Physician
#215-2211 west 4th ave.
Vancouver, BC
V6K 4S2

Intake Form

Name: ____ **Date:** ______________________

Address:____

Phone:______________________________________**Email:**_________________________

Would you like to receive Dr. Alexina Mehta's newsletter on the latest cutting edge natural health tips? Yes ☐

Please note you are welcome to unsubscribe from the newsletter whenever you wish.

Birth date:____

How did you hear about us:

____

Next of Kin to reach in case of Emergency:

____

Relationship:____
Phone:______________________________Text_____________________________________
Address:____

Context Of Care

Reasons you chose to come to this clinic:

____

Expectations you have from this visit:

____

Expectations you have from me personally as your doctor:

____

Are you currently receiving healthcare, if so from whom:

____

For what reason:

____

Please list your health concerns in order of priority:

1.
2.
3.
4.
5.

What do you believe is causing your most important health concerns?

Please list any medications and supplements you are currently taking, along with doses and the reason you are taking them:

Medications:	**Reason:**	**Date began:**	**Dose:**	**Helps? Yes or no**

Supplements:	**Reason:**	**Date began:**	**Dose:**	**Helps? Yes or no**

Review of Systems: **Please check boxes for any of the following that you have or have had previously.**

O = occasional, F = frequent, C = constant

O	F	C	General
☐	☐	☐	Allergy
☐	☐	☐	Chills
☐	☐	☐	Convulsions
☐	☐	☐	Dizziness
☐	☐	☐	Fainting
☐	☐	☐	Fatigue
☐	☐	☐	Fever
☐	☐	☐	Headache
☐	☐	☐	Loss of sleep
☐	☐	☐	Loss of weight
☐	☐	☐	Depression
☐	☐	☐	Nervousness
☐	☐	☐	Neuralgia
☐	☐	☐	Numbness
☐	☐	☐	Sweats
☐	☐	☐	Tremors

O	F	C	Muscle and Joint
☐	☐	☐	Arthritis
☐	☐	☐	Bursitis
☐	☐	☐	Foot trouble
☐	☐	☐	Hernia
☐	☐	☐	Lower back pain
☐	☐	☐	Lumbago
☐	☐	☐	Neck pain or stiffness
☐	☐	☐	Pain between shoulders
☐	☐	☐	Pain or numbness in:
☐	☐	☐	Shoulders
☐	☐	☐	Elbows
☐	☐	☐	Hands
☐	☐	☐	Hips
☐	☐	☐	Legs
☐	☐	☐	Knees
☐	☐	☐	Feet
☐	☐	☐	Painful tail bone
☐	☐	☐	Poor posture
☐	☐	☐	Sciatica
☐	☐	☐	Spinal curvature
☐	☐	☐	Swollen joints

O	F	C	Gastro-Intestinal
☐	☐	☐	Belching or gas
☐	☐	☐	Colitis
☐	☐	☐	Colon trouble
☐	☐	☐	Constipation
☐	☐	☐	Diarrhea
☐	☐	☐	Difficult digestion
☐	☐	☐	Abdominal distension
☐	☐	☐	Excessive hunger
☐	☐	☐	Gall bladder trouble
☐	☐	☐	Hemorrhoids
☐	☐	☐	Intestinal worms
☐	☐	☐	Jaundice
☐	☐	☐	Liver trouble
☐	☐	☐	Nausea
☐	☐	☐	Stomach pain
☐	☐	☐	Poor appetite
☐	☐	☐	Vomiting
☐	☐	☐	Vomiting of blood

O	F	C	Eyes, ears, nose, throat
☐	☐	☐	Asthma
☐	☐	☐	Colds
☐	☐	☐	Crossed eyes
☐	☐	☐	Deafness
☐	☐	☐	Dental decay
☐	☐	☐	Earache
☐	☐	☐	Ear discharge
☐	☐	☐	Ear noises
☐	☐	☐	Enlarged glands
☐	☐	☐	Enlarged thyroid
☐	☐	☐	Eye pain
☐	☐	☐	Failing vision
☐	☐	☐	Far sightedness
☐	☐	☐	Gum trouble
☐	☐	☐	Hay fever
☐	☐	☐	Hoarseness
☐	☐	☐	Nasal obstruction
☐	☐	☐	Near sightedness
☐	☐	☐	Nosebleeds
☐	☐	☐	Sinus infection
☐	☐	☐	Sore throat
☐	☐	☐	Tonsillitis

O	F	C	Cardio-Vascular
☐	☐	☐	Hardening of arteries
☐	☐	☐	High blood pressure
☐	☐	☐	Low blood pressure
☐	☐	☐	Pain over heart
☐	☐	☐	Poor circulation
☐	☐	☐	Rapid heart beat
☐	☐	☐	Slow heart beat
☐	☐	☐	Swelling of ankles

O	F	C	Respiratory
☐	☐	☐	Chest pain
☐	☐	☐	Chronic cough
☐	☐	☐	Difficult breathing
☐	☐	☐	Spitting up blood
☐	☐	☐	Spitting up phlegm
☐	☐	☐	Wheezing

O	F	C	Skin
☐	☐	☐	Boils
☐	☐	☐	Bruise easily
☐	☐	☐	Dryness
☐	☐	☐	Hives or allergy
☐	☐	☐	Itching
☐	☐	☐	Skin eruptions (rash)
☐	☐	☐	Varicose veins

O	F	C	Genito-Urinary
☐	☐	☐	Bed-wetting
☐	☐	☐	Blood in urine
☐	☐	☐	Frequent urination
☐	☐	☐	Poor kidney control
☐	☐	☐	Kidney infection
☐	☐	☐	Kidney stones
☐	☐	☐	Painful urination
☐	☐	☐	Prostate trouble
☐	☐	☐	Pus in urine

O	F	C	Women
☐	☐	☐	Congested breasts
☐	☐	☐	Cramps / backache
☐	☐	☐	Excess menstrual flow
☐	☐	☐	Hot flashes
☐	☐	☐	Irregular cycle
☐	☐	☐	Lumps in breasts
☐	☐	☐	Menopause
☐	☐	☐	Painful Menstruation
☐	☐	☐	Vaginal discharge

Females:

Onset of first menses was age___ Periods generally last ___ days and occur every ___ days.
Date of last period ____________ Bleeding is __Heavy __Moderate __Light
Do you experience PMS symptoms? _______
List:____
Please circle if you are: Pre-Menopausal/Menopausal/Post-Menopausal

Any Symptoms:____

Males:
Date of last prostate exam:____________
Trouble with urination? (frequency, hesitancy, pain, dribbling)________________________

PLEASE DESCRIBE YOUR FAMILY'S HEALTH: (be sure to include current age or age of death, major illness history, including diabetes, heart disease, osteoporosis, cancer, allergies, etc.)

Member	Living?/Age	Major illness or chronic conditions
Mother		
Father		
Siblings		
Mat. Grandmother		
Mat. Grandfather		
Pat. Grandmother		
Pat. Grandfather		

SURGERIES and IMAGING: Please describe your history with this.

Age:	Description:

DIET: Please describe a typical days diet for you

Breakfast	Lunch	Dinner	Snacks (what hour)

Sources and amounts of:

Caffeine:____
Alcohol:____
Smoking history and amount:____

WEIGHT and HEIGHT:

	Current	Past year	Past 5 years
Weight			
Height			

ALLERGIES: please list any severe allergies to drugs or foods that you know of:
1.
2.
3.

LIFESTYLE:
What are your primary sources of stress?
1.
2.
3.

How much do they impact you life?_____________________________________
Occupation? ____________________________ **Do you like your work?** ____________
How many hours do you work per week?______**Number of play/relaxation hours?**______
What do you do in order to manage stress and take care of yourself? : ______________
____
What is your exercise routine? ____
____
What do you do for enjoyment? ____
____

CURRENT HEALTH STATUS:
Date of last full physical: __________

Results of note from physical exam:

____

____

Do you have dental concerns, gum inflammation or gingivitis? Circle which and explain:

What do you believe is your greatest challenge?

What do you sense you need to do in order for your vision of health to happen?

Thank you for filling out this form. We look forward to working with you towards higher levels of health.

CONSENT FORM

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Dear patients:

Naturopathic examination includes: physical and clinical diagnosis, traditional Chinese medical diagnosis, energetic testing and lab work. Therapeutic procedures may include: homeopathy, spinal adjustment, botanical medicine, acupuncture, manual muscle therapy, craniosacral therapy, bowen therapy, clinical nutritional, lifestyle counselling, biofeedback and mind-body awareness,.

Occasionally, complications may arise. Any procedure intended to help may have complications. While the chances of experiencing complications are minimal, it is the practice of this clinic to inform our patients about them. These complications may include, but are not limited to: soreness, inflammation, soft tissue injury, dizziness, burns, bruising, stroke, and temporary worsening of symptoms. More serious complications are extremely rare.

I have read and understand the above statements regarding potential treatment side effects. I also understand that there is no guarantee or warranty for a specific cure result.

I am aware that 24 hours notice must be given for all cancelled appointments or the full fee for the visit is due. I understand that I am responsible for payment at the time services are rendered. Dispensary items and lab tests must be paid for in full before leaving the office.

Signature x____ Date x_________

Doctor's Signature x_______________________________________ Date x_________

PARENTAL CONSENT (if applicable)

If you are under the age of 19 parent consent is required for naturopathic treatment.

Signature of Parent/Guardian x______________________________ Date x_________

Thank you. We look forward to working with you.