Dr. Erika Schimek, ND
Doctor of Naturopathic Medicine

The Wolbeck Health Centre

Wolbeck Health Center • 160 Bayfield St., Barrie, Ontario • Ph. (705) 737 – 4711 • whc.bookings@gmail.com • www.doctorerika.com

REFERRED ACUPUNCTURE INTAKE FORM

Please take the time to fill in the following information. It provides a basis for further questions during your visit and helps provide insight into your health. All information is for office use only and is strictly confidential, and would only be release with written consent.

Patient Information

Full Name: _____ Date of Birth: _____ Age:_____ Gender: _____
Address: _____ City: _____Postal Code:_____
Home Phone: _____ Work Phone: _____ Cell Phone: _____
Email: _____ May we leave messages regarding your visits ? On what number? _____
How did you find out about the naturopathic services at this clinic? If referred please indicate from whom.
_____

Emergency Contact

Full name: _____
Relationship to Patient: _____
Home Phone/Cell: _____

Please List Other Health Care Providers

1. _____ Specialty:_____ Phone: _____
2. _____ Specialty:_____ Phone: _____
3. _____ Specialty:_____ Phone: _____

Medications and Supplements

List all CURRENT prescribed medications (incl. birth control):
Drug name: _____ Dosage: _____ Length taken: _____
Drug name: _____ Dosage: _____ Length taken: _____
Drug name: _____ Dosage: _____ Length taken: _____
List all CURRENT vitamins, minerals, herbs and supplements: _____
_____
List all PAST prescribed medications that you've taken for longer than 3 months: _____
_____

Current Health Concern

What is your health concern? _____
How did it start? _____
How long has this been present? _____ Have you had this before? _____ How often does it bother you? _____
Does anything make it feel better or worse? _____
What other types of treatment, if any, have you had for this complaint? _____
Which treatments have benefited you most? _____
How do you rate your general state of health? __ poor __fair __ good __ very good __ excellent
Comments: _____

Health History

Please check all that apply.

Easy bleeding/bruising	___	History of seizures	___	Pacemaker, or other electronic implant	___
History of bleeding disorder	___	Diabetes	___	Numbness in any area	___
History of fainting	___	Edema	___	Other impaired sense of touch	___
Low blood pressure	___	Paralysis	___	Anxiety/nervousness	___

Is there any chance that you are currently pregnant? _____ If yes, due when? _____
Please list any surgeries and hospitalizations within the past 6 months: _____
_____