

Please complete this form as fully as you are able. All information is held in strict confidence and used solely to support your care at Two Roots. If you have questions about any section, please ask.

Personal Information

Full name

Preferred name / name you go by

Date of birth

Gender

Female Male Non-binary Prefer to self-describe: _____ Prefer not to say

Pronouns (optional)

Contact Information

Street address

City

Province

Postal code

Country

Phone (primary)

Phone (secondary)

Email address

Preferred appointment format

In person — Perryvale Telehealth (video) Telehealth (phone)

Preferred contact method

Email Phone call Text message

Emergency Contact

Name

Relationship

Phone

How Did You Hear About Two Roots?

Word of mouth Social media Website / internet search Referral from a practitioner Other

If referred, by whom (optional)

Primary Reason for Visiting

In your own words, what has brought you to Two Roots? You do not need to provide a diagnosis. Describe what you are experiencing and what you are hoping for.

What is your primary concern or complaint?

How long have you been experiencing this?

What has helped so far, if anything?

What are you hoping this consultation will offer?

Current Healthcare Team

Please list any practitioners you are currently seeing.

Practitioner type	Name (if known)	Clinic or location

Current Medications and Supplements

Please list all medications, vitamins, supplements, and herbal preparations you are currently taking. This information is essential for safe clinical assessment.

Medication / supplement name	Dose	Frequency	Prescribed by / reason

If you have more than can fit above, please attach a separate list.

Known Allergies and Sensitivities

Please list any known allergies (food, medication, environmental, plant, or other):

Please list any known sensitivities or intolerances:

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