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NATUROPATHIC ADULT INTAKE FORM

Name _____ Date _____

Date of Birth _____ (M/D/Y) Gender: M F

Address _____

_____ Postal Code _____

Email _____ Would you like to join our e-newsletter? Yes No

Telephone: Home _____ Work _____ Cell _____

Preferred method to reach you (and best times) _____

Occupation _____ Number of children _____

Marital status: single partner married separated divorced widowed

Emergency Contact Name _____ Relation _____

Emergency Contact Number _____

How did you hear about us? _____

Current Health Care Providers:

Name _____	Name _____
Phone _____	Phone _____
Specialty _____	Specialty _____

Reasons for seeking Naturopathic Care:

Ailment	Date Started	Brief description

Current Medications

Medication	Dose	Date Started	For Which Condition	Any Side Effects

Current Supplements (Vitamins, Minerals and Herbs)

Supplement	Dose	Date Started	For Which Condition	Any Side Effects

PERSONAL MEDICAL HISTORY

Are you vaccinated? Yes No Do you get the Flu shot? Yes No

Have you taken antibiotics in the past 5 years? Yes No If yes, how many times? _____

Please list all known allergies (medication, foods, environmental)

Please list any hospitalizations, surgeries or serious injuries or illness

<u>Description</u>	<u>Date</u>	<u>Description</u>	<u>Date</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Past Illness Please check which of the following conditions you had in the past

- | | | | | |
|--------------------------------------|--|--|--|---|
| <input type="checkbox"/> Allergies | <input type="checkbox"/> Eating Disorder | <input type="checkbox"/> Mononucleosis | <input type="checkbox"/> Scarlet Fever | <input type="checkbox"/> Whooping Cough |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Herpes | <input type="checkbox"/> Parasites | <input type="checkbox"/> Sexual Abuse | <input type="checkbox"/> Worms |
| <input type="checkbox"/> Chicken Pox | <input type="checkbox"/> Malaria | <input type="checkbox"/> Rheumatic Fever | <input type="checkbox"/> Stroke | |
| <input type="checkbox"/> Cold Sores | <input type="checkbox"/> Mumps | <input type="checkbox"/> Rubella | <input type="checkbox"/> Tuberculosis | |

CURRENT HEALTH PROFILE

Height _____ Weight _____

Have you recently gained or lost any weight? If so, how much? _____

What is your blood type? (Please circle) O A B AB Not sure

Dietary Restrictions: Vegetarian Vegan Dairy/lactose intolerant Other: _____

How much water do you consume per day _____

Please indicate if you use any of the following:

Y	N		If yes, please state frequency, type and amount
<input type="checkbox"/>	<input type="checkbox"/>	Alcohol	
<input type="checkbox"/>	<input type="checkbox"/>	Tobacco	
<input type="checkbox"/>	<input type="checkbox"/>	Recreational Drugs	
<input type="checkbox"/>	<input type="checkbox"/>	Sedatives	
<input type="checkbox"/>	<input type="checkbox"/>	Laxatives	
<input type="checkbox"/>	<input type="checkbox"/>	Antacids	
<input type="checkbox"/>	<input type="checkbox"/>	Pain Relief Medication	
<input type="checkbox"/>	<input type="checkbox"/>	Coffee/Tea/Soft Drinks	
<input type="checkbox"/>	<input type="checkbox"/>	Artificial sweeteners	

Are you exposed to significant tobacco smoke? YES NO

Are you regularly exposed to toxins or other hazards? (through work, home, hobbies, etc)

Do you exercise regularly? YES NO

What do you do for exercise, how much, how often?

How is your energy level? (circle one) Low Fair Good High

Circle the level of stress you are experiencing on a scale of 1 to 10 (10 being the highest):

1 2 3 4 5 6 7 8 9 10

Circle the major cause(s) of your stress: Money Relationship Family Work Health

FAMILY HEALTH HISTORY (Grandparent, parent, sibling, child)

- | | | |
|--|--|--|
| <input type="checkbox"/> Allergy | <input type="checkbox"/> Diabetes | <input type="checkbox"/> Mental illness |
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Drug addiction | <input type="checkbox"/> Neurologic disorder |
| <input type="checkbox"/> Alcoholism | <input type="checkbox"/> Genetic disorder | <input type="checkbox"/> Osteoporosis |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> High cholesterol | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Celiac Disease | <input type="checkbox"/> High blood pressure | <input type="checkbox"/> Suicide |
| <input type="checkbox"/> Depression | <input type="checkbox"/> Heart disease | |
| <input type="checkbox"/> I don't know my family health history | | |
| <input type="checkbox"/> Other _____ | | |

REVIEW OF SYSTEMS

Please circle either **Y=Yes** (I have this symptom) or **P=in past** (I've had this symptom in the past) or **N=No**.

GENERAL

Change in appetite Y P N
 Change in thirst Y P N
 Fever/chills Y P N
 Fatigue/weakness Y P N
 Excessive sweating Y P N
 Slow wound healing Y P N

SKIN/HAIR/NAILS

Rash Y P N
 Itch Y P N
 Dry skin Y P N
 Acne Y P N
 Cold sores Y P N
 Eczema Y P N
 Psoriasis Y P N
 Warts Y P N
 Athlete's foot Y P N
 Hair loss Y P N
 Dandruff Y P N
 Brittle nails Y P N
 Nail ridges/spots Y P N
 Other : _____

HEAD

Headache Y P N
 Migraine Y P N
 Dizziness Y P N
 Fainting Y P N
 Injury Y P N
 Other : _____

EARS

Pain Y P N
 Infection Y P N
 Itching Y P N
 Hearing loss Y P N
 Ringing in ears Y P N
 Other: _____

EYES

Near sightedness Y P N
 Far sightedness Y P N
 Pain Y P N
 Double vision Y P N
 Blurry vision Y P N
 Glaucoma Y P N
 Sties Y P N
 Cataract Y P N
 Itching Y P N
 Seeing spots Y P N
 Sensitivity to bright lights Y P N
 Droopy eyelid Y P N
 Dry eyes Y P N
 Discharge Y P N
 Redness Y P N
 Date of last eye exam : _____
 Other : _____

NOSE/SINUSES

Nose bleeds Y P N
 Runny nose Y P N
 Sinus pain Y P N
 Sinus infection Y P N
 No. of colds/year _____
 Other : _____

MOUTH

Canker sores Y P N
 Loss of taste Y P N
 Dry mouth Y P N
 Bleeding gums Y P N
 Bad taste in mouth Y P N
 No. of dental fillings _____
 Type: Silver White
 Date of last dental exam: _____

THROAT

Sore throats Y P N
 Hoarseness Y P N
 Swollen glands Y P N
 Other : _____

RESPIRATORY

Cough Y P N
 Wheezing Y P N
 Shortness of breath Y P N
 Snoring in sleep Y P N
 Asthma Y P N
 Bronchitis Y P N
 Pneumonia Y P N
 Other: _____

CARDIOVASCULAR

Chest Pain Y P N
 Palpitations Y P N
 Heart murmur Y P N
 High blood pressure Y P N
 High cholesterol Y P N
 Swollen ankles Y P N
 Varicose veins Y P N
 Other: _____

GASTROINTESTINAL

Abdominal pain Y P N
 Difficulty swallowing Y P N
 Heartburn Y P N
 Indigestion Y P N
 Bloating Y P N
 Nausea Y P N
 Vomiting Y P N
 Belching/flatulence Y P N
 Constipation Y P N
 Diarrhea Y P N
 IBS Y P N
 Hemorrhoids Y P N
 Liver disease Y P N
 Gall Bladder disease Y P N
 No. of bowel movements per day: _____

MALE

Penile discharge Y P N
 Lesions/sores Y P N
 Testicular pain Y P N
 Testicular mass Y P N
 Impotence Y P N
 Decreased libido Y P N
 STI Y P N
 Other : _____

FEMALE

Age at first period: _____
 Date of last period: _____

Length of cycle: _____
 Loss of cycle Y P N
 Irregular cycles Y P N
 Excessive flow Y P N
 Painful periods Y P N
 PMS Y P N
 Are you currently pregnant?
 Y N

Sexually active Y P N
 Contraception used: _____

Painful intercourse Y P N
 Decreased libido Y P N
 Difficulty conceiving Y P N
 Miscarriage Y N
 No. of pregnancies: _____
 Vaginal discharge Y P N
 Vaginal itch Y P N
 STI Y P N
 Date of last PAP: _____
 Other : _____

BREAST

Tenderness Y P N
 Lump Y P N
 Nipple discharge Y P N
 Other: _____

URINARY

Frequent urination Y P N
 Frequent urination at night Y P N
 Incomplete urination Y P N
 Urgency Y P N
 Burning Y P N
 Blood in urine Y P N
 Passage of stone Y P N
 Urinary tract infection Y P N
 Other: _____

ENDOCRINE

Thyroid problems Y P N
 Cold intolerance Y P N
 Hot intolerance Y P N
 Increased thirst Y P N
 Increased hunger Y P N
 Hypoglycemia Y P N
 Diabetes mellitus Y P N
 Other: _____

MUSCULOSKELETAL

Neck pain Y P N
 Back pain Y P N
 Carpal tunnel syndrome Y P N
 Tendonitis Y P N
 Muscle pain Y P N
 Joint pain Y P N
 Arthritis Y P N
 Gout Y P N
 Other: _____

NEUROLOGIC

Seizures Y P N
 Involuntary movement Y P N
 Muscle weakness Y P N
 Paralysis Y P N
 Numbness Y P N
 Clumsiness Y P N
 Memory loss Y P N
 Learning difficulty Y P N
 Other: _____

BLOOD/LYMPH

Anemia Y P N
 Easy bruising Y P N
 Low Iron Y P N
 Low B12 Y P N
 Blood clots Y P N
 Blood transfusion Y P N
 Swollen glands Y P N
 Other: _____

MENTAL/EMOTIONAL

Problems sleeping Y P N
 Anxiety Y P N
 Phobias Y P N
 Panic episodes Y P N
 Depression Y P N
 Mood swings Y P N
 Addiction Y P N
 If so, what type?

 Other: _____

MY HEALTH GOALS:
(check all that apply)

- Have more energy
- Get better sleep
- Be free of pain
- Improve sex drive
- Have less colds and flu
- Get rid of allergies
- Reduce use of medication
- Lose weight
- Have more muscle tone
- Burn more body fat
- Reduce stress
- Be less depressed
- Be less moody
- Improve memory
- Think more clearly
- Feel more motivated
- Reduce my risk of disease
- Slow down accelerated aging
- Maintain a healthier life longer

POLICIES AND PROCEDURES

Fee Schedule:

Type of Visit	Duration	Cost
First visit	90 minutes	\$170.00
Follow up visits	15 minutes	\$ 40.00
	30 minutes	\$ 70.00
	45 minutes	\$ 95.00
	60 minutes	\$135.00
Missed appointment fee		\$ 40.00

We offer direct billing for most insurance providers, please ask for more details.

Otherwise payment is due at time of service, payable by Debit, Mastercard, Visa or cash.

Lab Services

Lab tests are available as part of your health assessment. Cost is dependent on the test and may be covered by your insurance provider. These include:

- Food sensitivity test
- Microbiology test (including Candida)
- Comprehensive stool analysis
- Saliva hormone test
- Adrenal function test
- Heavy metal test (hair and urine tests)
- Organic Acid test
- Blood tests

Please note we cannot bill directly to insurance companies for laboratory expenses.

Professional Supplements

You may be prescribed supplements at some of your visits. For your convenience we carry a variety of professional grade supplements. You may purchase them in office, or you may purchase your supplements from a health food store of your choice.

Cancellations

If you need to cancel your appointment, please call us as soon as possible.

Failure to give 24 hours notice will result in a missed appointment charge.

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INFORMED CONSENT

The principles and practices of Naturopathic Medicine and other supportive therapies will be practiced to assist the body's own ability to heal and to improve the quality of life and health through natural means. Your ND will conduct a thorough case history and a physical exam. She may also request additional blood and/or urinary laboratory or functional tests as part of your naturopathic work-up.

It is important to recognize that even the gentlest therapies come with some health risk. These risks include:

- aggravation of pre-existing symptoms
- allergic reaction to supplements or herbs
- pain, fainting, bruising or injury from acupuncture or intramuscular injection

Although generally safe, some treatments have the potential for complications in certain physiological conditions. Thus, it is important to provide a complete health history and advise the ND of:

- all current medications (including over the counter drugs and supplements) and any changes in these medications
- pregnancy or breastfeeding status

PRIVACY POLICY

Protecting your personal information is of vital importance to us. Our privacy policy is as follows:

- only necessary information is collected about you
- only with your consent do we share information with others outside the clinic
- storage, retention and destruction of your information complies with existing law
- our policy conforms to privacy legislation and standards of the College of Naturopaths of Ontario

We collect personal information in order to:

- assess your health and provide treatment
- establish and maintain contact with you for appointments, billing and follow-up care
- facilitate your insurance claims
- comply with regulatory requirements and laws under the College of Naturopaths of Ontario

I have read the Naturopathic Pricing Policy posted, and I understand that I am fully responsible for any fees relating to any services rendered or products sold to me.

I have read the cancellation policy and understand that 24 hours notice is required to avoid charges. I have also read and understood the consent form and privacy policy.

Date: _____

Patient Name: _____

Patient (or Guardian) Signature: _____

Naturopathic Doctor's Signature: _____