Confidential Patient Intake Form

Today's Date:___________________

Name: ___________________________________Age: ____ Date of Birth: ____________ Gender: M F
Address: _________________________________ City: __________________ Postal Code: _________
Home phone: _____________________________ Work or Other phone: _________________________
Profession: _________________________Employer: _____________________Full or Part-Time? (circle)
E-mail address: ____
Circle one: Married Single Widowed Divorced Separated Common-law Same sex
Live with: Spouse Partner Parents Children Friends Alone

Other health care providers (name and phone number):

1. ___________________________________ Phone _________________________________
2. ___________________________________ Phone _________________________________
3. ___________________________________ Phone _________________________________

Do you have extended medical insurance? ____
Person to notify in an emergency? _______________Relationship: _____________ Phone: ________
How did you hear about this clinic? ____

CURRENT HEALTH CONDITION

What health concerns brought you here today? Please list in order of importance to you:

1.____
2. ____
3. ____
4.____

Has anything recently changed or become worse? ____
____

Please list the five most significant stressful events in your life. Do any of these continue to affect you?

1. ____
2. ____
3. ____
4. ____
5. ____

PERSONAL HEALTH HABITS

Height: ______ Current weight: _____ Weight 1 year ago: _____ Maximum weight: _____ when? _____
Smoker: • Yes • No Smoked _______ years Amount/day:___________ Year stopped: __________
Alcohol use: • Yes • No Type: _________________________ Frequency: __________________________
Recreational drug use: • Yes • No Type: ____________________ Frequency: ______________________
Coffee: • Yes • No ________ cups / day Tea: • Yes • No ________ cups / day
Water: ________ cups / day Purified water: • Yes • No Tap water: • Yes • No
Are there any food groups that you avoid? • Yes • No ____
Are there any food groups that you eat a lot of? • Yes • No ______________________________________
Do you eat dairy products? • Yes • No ____
On a scale of 1 to 10, with 10 being the highest, please rate your average STRESS level: ______________
On a scale of 1 to 10, with 10 being the highest, please rate your average ENERGY level: ______________

How many hours of sleep do you get a night? _____________Do you wake up feeling rested? • Yes • No
Regular exercise? • Yes • No Type: _______________ Duration: _________ Frequency: __________
Women: Are you currently pregnant? • Yes • No • Not sure
Type of birth control used: _____________________If birth control pill use, how many years? ________
Were you breast fed and for how long? ____
What was your health as a child until age 12? ____
How many times have you had antibiotics in your life? _______________________________________

MEDICAL HISTORY

Please indicate any serious conditions, illnesses, injuries and hospitalization. Include approximate dates.
____
____
____
List any allergies (medicines, environment, food, etc.)?
____
____
Check any of the following that you currently use, and specify the frequency or how long you have been using them:
Anti-histamine ____________ Antacids __________ Cortisone ________ Anti-inflammatories ________
Pain relievers _________ Aspirin __________ Sleeping Pills ________ Anti-depressive _______
Laxatives_____________
Please indicate all drugs and medications which you are currently prescribed, the reason and the effect:
____
____
If currently taking any supplements please list brands and dosages of all products you are taking and the reason for taking them: ____
____
____
Please circle any of the following conditions that pertain to you personally:

- ○ Asthma
- ○ Allergies
- ○ Arthritis
- ○ Anemia
- ○ Alcohol Abuse
- ○ Blood Pressure Issues/Stroke
- ○ Bleeding Problems
- ○ Bladder/Urinary Problems
- ○ Cancer (please indicate type)
- ○ Chest pain
- ○ Colitis
- ○ Frequent colds, flu, sore throats
- ○ Diabetes
- ○ Digestive Disturbances
- ○ Ear Problems
- ○ Eating disorders
- ○ Edema
- ○ Fatique, chronic

○ Female Gynecological Problems
○ Gall Bladder/ Liver Problems
○ Gum/ Teeth Problems
○ Hay Fever
○ Headaches
○ Head injury/ Serious Injury
○ Hepatitis
○ Heart Disorders
○ Jaundice
○ Joint Problems
○ Kidney Problems
○ Lung Problems
○ Occupational Exposure to Toxic Substances
○ Parasites
○ Psychological Difficulties/ suicidal/ depression
○ Sexually Transmitted Diseases (herpes, chlamydia, gonorrhea)
○ Skin Problems
○ Thyroid

FAMILY HISTORY- Has a close relative (parent, child, sibling, grandparent) had any of the following:

	Who?		Who?
Allergies		Diabetes	
Arthritis		Depression	
Asthma		Drug abuse/alcoholism	
Epilepsy		Bleeding problems	
Heart Disease		Multiple sclerosis	
High Blood Pressure		Kidney disease	
Stroke		Thyroid problems	
Cancer		Other	

Informed Consent

Naturopathic Medicine is the treatment and prevention of disease by natural means. Naturopathic Doctors assess the whole person, taking into consideration physical, mental, emotional and spiritual aspects of the individual. Gentle, non-invasive techniques are generally used in order to stimulate the body's inherent healingcapacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counseling, clinical nutrition (primary via supplementation), botanical medicine, homeopathy, Eat Right for Your Blood and Genotype, hydrotherapy, and physical medicine. Individual diets and nutritional supplements are recommended to address deficiencies, treat disease processes, and promote health. The benefits may include increased energy, increased gastrointestinal function, improved immunity, and general well-being.

Botanical medicine is a plant based medicine that involves the use of herbal teas, tinctures, capsules, and other forms of herbal preparations to assist in recovery from injury and disease.
Homeopathy is a form of medicine based on the Law of Similars – that is, the use of tiny doses of the very thing that causes symptoms in health people. These minute doses of plant, animal, or mineral origins are used to stimulate the body's ability to heal itself. Homeopathy is a powerful tool that effects healing on a physical and emotional level.

Hydrotherapy refers to the use of hot and cold water applications to improve circulation and stimulate the immune system.

Lifestyle counseling involves identifying risk factors and making recommendations to help optimize one's physical, mental, and emotional environment.

During you initial visits, your Naturopathic Doctor will take a thorough case history and perform a basic/complaint-oriented physical examination, and when indicated, take urine samples or perform other
laboratory testing.
Even the gentlest therapies may cause complications in certain physiological conditions this depends greatly on
the individual and the extent of the illness. Some therapies must be used with caution in certain diseases such
as diabetes, heart, liver or kidney disease.
It is very important, therefore, that you inform your naturopathic doctor immediately of any disease process that you are suffering from as well as any medications (prescription or over-the-counter) that you are taking. If you are pregnant, suspect you are pregnant, or you are breast-feeding, advise your doctor immediately.

Health risks associated with Naturopathic Medicine include but are not limited to:
• Aggravation of pre-existing symptoms during the healing process.
• Allergic reactions to supplements or herbs.
• Pain, bruising or injury from acupuncture.
• Fainting or puncturing of an organ with acupuncture needles.

______
Initials

I understand that a record will be kept of the health services provided to me. This record will be kept confidential and will not be released to others without my consent, unless required by law. I understand that I may look at my medical record at any time and can request a copy of it by paying the appropriate fee.

______
Initials
I understand that the Naturopathic Doctor will answer any questions that I have to the best of her ability. I understand that the results are not guaranteed. I do not expect the doctor to be able to anticipate and explain all risks and complications. With this knowledge, I voluntarily consent to diagnostic and therapeutic procedures mentioned above, except for (please list any exceptions):

______
Initials
I understand that fees and supplements are to be paid for at the time of the consultation.

______
Initials
I understand that a fee will be charged (Missed Appointment Fee) for any missed appointments or cancellations with less than 24 hours notice.

As the patient, you are responsible for the total charges incurred for each visit. We accept cash, or cheque at this time.

If you have coverage for Naturopathic Medicine, you are responsible for billing your own insurance company – we will provide you with all of the information necessary to send your claim for reimbursement.

Your Naturopathic Doctor may prescribe supplements that can be purchased from our in-house dispensary, or elsewhere. Most insurance companies do not cover the supplements that we prescribe and dispense.

I have read and understand the above-stated policies and information. I intend this consent form to cover the entire course of treatment for my present condition. I understand that I am free to withdraw my consent and to discontinue participation in these procedures at any time.
Patient Name (please print): ____
Signature of Patient or Parent / Guardian: ____
Date: ____________________________