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ADULT NATUROPATHIC INTAKE FORM

Name: First____________________ Last____________________

Address: ____________________

City____________________ Prov.____________________ Postalcode____________________

Phone: home____________________ Mobile____________________ Bus____________________

Email:____________________

Occuption:____________________

Emergency Contact____________________ Phone____________________

Birthdate: (day/month/year)____________________

Height____________________ Weight____________________ 1 year ago____________________

Present Health Concerns and Symptoms

1)____________________

2)____________________

3)____________________

4)____________________

5)____________________

Allergies: (medications, food, environmental)____________________

____

Medical Conditions:

____

____

____

Prescription Medications ____________________

____

____

____

Over the Counter Products (Tylenol, ASA, Antacids, etc.)

____

____

Supplements, Vitamins/Minerals, Herbal Remedies, Homeopathics

____

____

____

Surgeries, Hospitalizations, Illnesses

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____

____

Dental (amalgam filings and/or root canals)

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____

____

Recent Lab Tests and Imaging (x-rays, MRI)

____

____

____

Family Health History/ Unknown/Adopted__________________

Relationship	Age or Deceased	Health Condition (Cancer, Heart Disease, Diabetes, Genetic Illness)
Mother		
Father		
Maternal Grandmother		
Maternal Grandfather		
Paternal Grandmother		
Paternal Grandfather		
Sisters		
Brothers		

Appetite (weak/strong)

Foods You Avoid

Foods You Crave

Typical Dietary Intake

Arising	Breakfast	Lunch	Dinner	Snacks

Fluid Intake (water, coffee/tea, juice, carbonated beverages)

Bowel Movements (frequency)

Loose stools?	Mucous in stools?
Diarrhea?	Gas?
Hard stools?	Bloating?
Difficulty passing?	Heartburn? Reflux?
Blood in stools?	Abdominal pain?
Undigested food in stools?	

Do you have your gallbladder?____________________ Appendix?____________________

Continued

Lifestyle Habits

Interests and Hobbies______________________________

Exercise (type, # times/week)______________________________

____

Alcohol Intake (type, amount/wk, type)______________________________

Tobacco Use? __________ Amount/day__________years of use__________________

Recreational Drug Use?__________(amount, type)______________________________

Energy: rate from 1 (low) to 10 (high) Morning________Midday________Evening________

Stress: rate from 1 (low) to 10 (high)______________________________

Recent Stressful Events______________________________

Tools to Reduce and Balance Stress______________________________

Sleep: # of hrs/night____________easy to fall asleep?________wake midsleep?________

Are you sexually active?______low libido?______Type of Contraception______________

Female:

Length of Menstrual Cycle (ie 28 days) Duration of Menses (ie 5 days)

____

Menstrual Flow or PMS Symptoms? (Heavy or light flow, clotting, mid cycle bleeding, pain, bloating, headaches, breast tenderness, mood changes, cravings______________________________

____

Menopause/Perimenopausal symptoms? (hot flashes, poor memory, mood changes, low libido, painful intercourse, vaginal dryness ______________________________

____

Male: Indicate if you experience any of the following;

Low libido	Testicular pain
Sexually transmitted disease	Genital sores
Infertility/low sperm count	Discharge
Difficult or delayed urination	Testicular lumps
Prostate condition	Hernia

Toxic Exposure (Mercury Fillings and Removal, Occupational Exposure, Pesticides/Fertilizers)______________

____

Indicate present symptoms with checkmark, past symptoms with ‘P’

General	Fatigue		Weight gain	
	Change in appetite		Weight loss	
	Change in thirst		Poor sleep	
	Cravings		Chills or fever	
Skin and Hair	Dryness		Eczema	
	Rash		Psoriasis	
	Hives/allergic reaction		Itching	
	Loss of hair		Recent moles/growths	
	dandruff		Other skin changes	
Ears, Eyes, Nose. Throat	Eye pain		Sinus congestion/drip	
	Change in vision		Sinus infection	
	Cataracts		Loss of smell	
	Ear pain		nosebleeds	
	Ringing in Ears		Jaw pain	
	Dizziness		Sore throat	
	Facial pain		Swollen lymph glands	
	Loss of taste		Thyroid swelling/nodes	
	Mouth sores		Headaches	
Cardiovascular	Chest pain		Palpitations	
	High blood pressure		Irregular heart rate	
	Low blood pressure		Fainting	
	History of heart attack		Varicose veins	
	Pacemaker		Deep leg pain	
	Anemia		Cold hands/feet	
	Shortness of breath		Easy bruising	
Respiratory	Difficult breathing		Emphysema	
	Chronic cough		Wheezing	
	Bronchitis		Chronic phlegm	
	Asthma		Blood in phlegm	

Continued

Muscles, Joints, Bone	Neck pain		Joint immobility	
	Back pain		Joint replacement surgery	
	Skeletal muscle pain		Ligament surgery	
	Muscle weakness		Whiplash injury	
	Arthritis		Bone fracture	
	Bursitis		Osteopenia/porosis	
Gastrointestinal	Nausea/vomiting		Constipation	
	Heartburn/reflux		Diarrhea	
	Constant hunger		Rectal burning/pain	
	Ulcer		Hemorrhoids	
	Gall stones		Gas/bloating	
Neurological	Anxiety		Seizures	
	Depression		Concussion	
	Irritability		Lack of coordination	
	Emotional swings		Extremity numbness	
	Poor memory		Extremity tingling	
	dizziness		paralysis	
Infections	Strep throat		Hepatitis	
	Mononucleosis		HIV/AIDS	
	Tuberculosis		Chronic cold/flu	
	Poor wound healing		Frequent antibiotic use	
Urinary	Frequent urination		Pain with urination	
	Frequent infection		Wakes at night to urinate	
	Urgency to urinate		Urinary tract infection	
	Incontinence		Blood in urine	
	Urine leakage		Kidney stones	
Hormonal	Night sweats		Mood changes	
	Mood changes		Menstrual cycle changes	
	Weight gain		Joint pain	
	Weight loss		Poor energy/fatigue	

I ATTEST THAT THE INFORMATION PROVIDED IS TRUE AND ACCURATE TO THE BEST OF MY KNOWLEDGE.

Signature____Date____________________________

DECLARATION AND CONSENT TO TREATMENT

Naturopathic Doctors minimize the risk of harmful side effects by supporting the body's own ability to heal and by using the least invasive procedures for diagnosis and treatment whenever possible. However, even the gentlest therapies have potential for complications.

Some therapies must be used with caution in certain diseases such as diabetes, heart, liver or kidney disease, or in specific patient populations such as pregnant or lactating women, very young children, or patients taking multiple medications. It is very important that you inform your Naturopathic Doctor immediately of:

- aggravation of pre-existing symptoms
- allergic reactions to supplements or herbs
- pain, bruising or injury from acupuncture or blood draws
- fainting or puncturing of an organ with acupuncture needles

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 unless so directed by myself or when law requires it. I understand that I may look at my medical record at anytime and can request a copy of it or have a report drawn up by paying the appropriate fee. I understand that information from my medical record may be analyzed for research purposes and that my identity will be protected and kept confidential.

I understand that my Naturopathic Doctor will answer any questions that I have to the best of his/her ability. I understand that the results are not guaranteed. I do not expect the Naturopathic Doctor to be able to anticipate and explain all risks and complications. I will rely on the Naturopathic Doctor to exercise judgment during the course of the procedure which they feel at that time is in my best interests, based on the facts then known.

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.

If I am unable to make my appointment I must provide advance notification within 48 hours in which case no charge will be applied.

THIS IS TO ACKNOWLEDGE that I have been informed and I understand that:

l. Any treatment or advice provided to me as a patient is not mutually exclusive from any treatment or advice that I may now be receiving from another licensed health care provider, or may receive in the future;

ll. I am at liberty to seek or continue medical care from a physician or surgeon or other health care provider qualified to practice in Alberta;

lll. No employee, student or anyone else under the Clinic's direction or control is suggesting or advising me to refrain from seeking or following the directions of another licensed health care provider;

lV. The treatment and therapies rendered or recommended by this Clinic may be different than those usually offered by a medical doctor or other licensed health care provider.

I DECLARE that I have received a full and complete explanation of the treatment of services that I may receive and hereby authorize and consent to treatment.

I AGREE to pay my full account at the time of each visit or treatment, including fees for services, cost of supplements and remedies, as well as other applicable fees. I understand that there is a fee for completing insurance forms, letter writing, and telephone consultations greater than 10 minutes and emails that take greater than 10 minutes to answer. Notice of 48 hours required for appointment cancellation, otherwise a $35 administrative fee will be charged.

Patients' Full Name____Date of Consent:__________________________

Signature of Patient____