Intake Form

Personal Information

Date: ___________________

Name: ____ Sex: ☐ M ☐ F

Age: ______ Birth Date: ____________

Address: ____

City: __________________ Province: ______ Postal code: _________________

Telephone (Home): ____________________ (Work): ______________________

Email: ____

Occupation: __________________________________ Employer: ______________________________________

Marital status: ☐ Married ☐ Single ☐ Widowed ☐ Divorced ☐ Separated ☐ Common-Law

Number of children: _________________

Other health care providers you are seeing:

Name			
Occupation/Specialty			
Address			
Phone			
Fax			

In case of emergency, contact: _________________________ Relationship: ________________

Address: ____ Phone: _______________________

How did you hear about the clinic? _____________________________

Have you seen a Naturopathic Doctor before: ☐ Yes ☐ No If yes, for what ailment(s)? ______________________

Current History:

What health concerns brought you in to the clinic today?

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

Has anything changed recently or become worse?

____

____

____

Medication and Supplement History

Please list all supplements, herbs, and medications you are currently taking:

Medication/Supplement	Dosage	Start Date	Reason

When was the last time you used antibiotics?______________ Reason:______________________________

How many times (approx) have you used antibiotics in your life? ____________

Do you frequently use any of the following? (check all that apply)

☐ Aspirin ☐ Laxatives ☐ Antacids ☐ Diet pills Birth control: ☐ Pills ☐ Implants ☐ Injections ☐ Patch

☐ Alcohol. Which type(s): ______________________ How many drinks/day or week: ________________

☐ Caffeine Form: _____________________________ Amount/day: ____________________

☐ Tobacco Form: _____________________________ Amount/day: ____________________

☐ Recreational drugs. What type? _____________ How often: _______________________

Do you have a past history using any of the above?

____

Do you have any allergies (medicines, environmental, etc.)?

____

____

Please list any past medications/supplements:

Medication/Supplement	Start Date	Reason

Please indicate what immunizations you have had:

☐ DPT (diphtheria, pertussis, tetanus) ☐ Haemophilus influenza B ☐ Hepatitis A

☐ Tetanus booster. When: ___________ ☐ "Flu" ☐ Hepatitis B

☐ MMR (measles, mumps, rubella) ☐ Polio ☐ Smallpox

Other: ________________________________ Any adverse reactions? _________________________________

Health History

How would you describe you general state of health: ☐ Excellent ☐ Good ☐ Fair ☐ Poor

Please list any serious conditions, illnesses, injuries, fractures, hospitalizations:

Condition, Illness, Injuries, Fractures, Hospitalizations	Date	Complications or long term consequences

Family History

Please indicate whether you or any of your family members have, or have had the following:

Illness	Relative	Illness	Relative
Alcoholism		Diabetes	
Allergies		Drug Abuse	
Alzheimer's Disease		Heart Disease	
Arthritis		High Blood Pressure	
Asthma		Kidney Disease	
Cancer (Indicate type)		Osteoporosis	
Mental Illness		Suicide	
Liver Disease		Other	

Gastrointestinal Health

How often do you have a bowel movement? __________________

Do you tend towards: ☐ Constipation ☐ Diarrhea ☐ Both ☐ Neither

Have you had blood in your stool? ☐ Yes ☐ No Mucus? ☐ Yes ☐ No Black, tarry stool? ☐ Yes ☐ No

Do you have gas? ☐ Yes ☐ No Bloating? ☐ Yes ☐ No Reflux? ☐ Yes ☐ No

Diet

Do you have any food allergies or intolerances?

____

Do you have dietary restrictions (religious), vegetarian/vegan, etc)?

____

Do you have any strong food cravings or aversions? If so, what types of foods?________________________

How much water do you drink per day? __________________________

Please include a sample of a typical day's diet:

Breakfast	Lunch	Dinner	Beverages/Snacks

Lifestyle/Environment/Emotional Health

How would you rate your energy level in general, on a scale from 1-10 (10 being the best): ____________________

Do you sleep well? ☐ Yes ☐ No

On average, how many hours of sleep do you get a night? __________

Do you wake up at night? If so, what time? _______________

Do you exercise regularly? ☐ Yes ☐ No

What do you do for exercise? How often? ____________________________

____

Are you exposed to significant tobacco smoke (work, home, etc)? ☐ Yes ☐ No

Are you frequently exposed to animals (work, pets, etc)? ☐ Yes ☐ No

Are you regularly exposed to toxins or other hazards? ☐ Yes ☐ No

Which ones?____

Please rate your stress level: ☐ Low ☐ Average ☐ High ☐ Unbearable

How would you describe the emotional climate of your home?

____

How do you deal with your stress?

____

Do you get irritable or angry easily?

If yes, explain: ____

Do you worry often?

If yes, explain: ____

Do you often experience depression? If yes, explain:

____

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Women's Health

Are you currently pregnant? ☐ Yes ☐ No

Do you get Pap smears? ☐Yes ☐No Last Pap date: ___Have you had an abnormal Pap: ☐Yes ☐No

Age of first period: ______ Is your period regular? ☐ Yes ☐ No Length of cycle (Days): _____ Flow (Days) _____ Are you menopausal? ☐ Yes ☐ No If yes, age of last period: _________

Are you currently sexually active? ☐ Yes ☐ No Have you been sexually active in the past? ☐ Yes ☐ No Current form of contraception:__________________________

Have you ever had a sexually transmitted infection? ☐ Yes ☐ No

Number of pregnancies? _______ Live births? _______ Miscarriages? ________ Abortions? _________

Do you have any sexual problems of concern? Yes no. If yes, please explain: __________________________

Men's Health

Do you get regular screening tests done (blood work, prostate examinations)? ☐ Yes ☐ No

Date of last prostate exam? ____________

Are you currently sexually active? ☐ Yes ☐ No Have you been sexually active in the past? ☐ Yes ☐ No

Current form of contraception:__________________________

Have you had any of the following: ☐ Testicular pain ☐ Hernia ☐ STI's ☐ Discharge ☐ Sores

Do you have any sexual problems of concern? ☐ Yes ☐ No. If yes, please explain:

Is there anything that you feel is important that has not been covered?

Thank you for taking the time to fill out this form. The information collected will help you on your journey to achieving better health!

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 healing capacity.

A number of different approaches may be used throughout the course of treatment. Treatment modalities include diet, lifestyle counselling, clinical nutrition (primary via supplementation), botanical medicine, homeopathy, Asian medicine and acupuncture, 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, improved gastrointestinal function, enhanced immunity, and general well-being.

Botanical medicine is 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 healthy people. These minute doses, of plant, animal, or mineral origin, 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.

Asian medicine includes the use of acupuncture, Eastern herbs and dietary changes to eliminate disease and balance body functions. Acupuncture refers to the insertion of sterilized disposable needles through the skin into underlying tissues at specific points on the body. Eastern herbs may be given in the form of pills, tinctures, or decoctions (strong teas) to be taken internally or used externally as a wash. Dietary advice is based on traditional Chinese medical theory.

Physical medicine refers to the use of hands-on techniques such as soft tissue and spinal manipulation, as well as various types of electrical stimulation and therapeutic ultrasound for the purpose of treating musculoskeletal and neurological problems.

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

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

During your 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 for further testing, or blood samples for lab investigation.

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 venipuncture or acupuncture
- Fainting or puncturing of an organ with acupuncture needles
- Muscle strains and sprains or disc injuries from spinal manipulation

A record will be kept of the health services provided to you. This record will be kept confidential and will not be released to others without your 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.

The results of naturopathic medical care 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,

Fees and supplements are to be paid for at the time of the consultation.

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, debit, cheque or visa. 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 hereby authorize and consent for naturopathic treatment and assessment by Amelia Croll (ND cand.), Vincenza Rotulo (ND), or Stephanie Beynon (ND). I understand that Amelia Croll is a non-registrant working towards licensing Feb/2011. 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 Guardian: ____

Date: ____

We look forward to working with you to help you achieve better health.

Naturopathic medical services are covered under many extended health care plans. Check your policy for coverage details.